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Overview

Certain criminal justice system populations may be recognized as having specific needs; the consensus panel recommends that whenever possible, treatment be modified to meet those needs. A thorough client assessment will enable treatment providers to determine what modifications to treatment are required. However, the panel also recognizes that in order to explain different types of treatment modifications and the need for those modifications it is necessary to group clients according to certain socially defined categories that mark their relationship to a dominant identity. This chapter provides a basic overview of treatment needs of offenders belonging to subpopulations including women; men; violent offenders; gay, lesbian, and bisexual offenders; clients with physical and sensory disabilities; older adults; people with co-occurring mental and substance use disorders; people with infectious diseases; and sex offenders.

Treatment Issues Related to Cultural Minorities

There is no denying that the ethnic and cultural composition of offender populations is quite different from that of society as a whole. African Americans are disproportionately represented in jails, prisons, and community supervision programs in comparison with their numbers in the general population. They represented 39.2 percent of the jail population and 44.1 percent of the prison population in 2003, 41 percent of those on parole, and 30 percent of those on probation. According to the 2000 Census, however, those who said they were African American alone or in combination with one or more other races represent only 13 percent of the U.S. population. Hispanics/Latinos, of any race, are also somewhat overrepresented, representing 15.4 percent of the jail population and 19.0 percent of the prison population in 2003, but only 13.3

percent of the U.S. population according to 2002 Census data (Ramirez and de la Cruz 2002). Caucasians are underrepresented at each stage of the criminal justice process, making up only 43.6 percent of the jail population and 35 percent of the prison population in 2003, 40 percent of those on parole, and 56 percent of probationers in 2003, but 77.1 percent of the U.S. population (Glaze and Palla 2004; Harrison and Beck 2004; Harrison and Karberg 2004; U.S. Census Bureau 2001).

McKean (1994) summarizes four somewhat overlapping theoretical perspectives to explain why certain racial or ethnic groups are overrepresented among offenders:

- Social isolation
- Social disintegration
- Resource deprivation
- Violent cultural orientation

These theoretical stances inform substance abuse treatment as well. The social isolation model states that the dominant group will always choose to maintain a social distance between itself and minority groups, and to this end may employ discriminatory laws and policies. Social disintegration models look at how weakened informal and institutional social controls lead to increased crime. The resource deprivation theory emphasizes that economic variables such as unemployment, poverty, and income inequality are associated with crime. The idea of a subculture of violence implies that violent interactions are more accepted among some groups than others, for example in gang culture.

In a study of Alaska Native men, Glass and Bieber (1997) found criminal activity to be related to social disintegration caused by acculturative stress. This stress develops when members of a minority culture are pressured to adapt to a dominant culture. The bicultural individuals in their study had the highest levels of acculturative stress and violent behavior and seemed more prone to identity issues, unstable interpersonal relationships, and unstable emotions. The authors

surmise that these individuals are not accepted in either culture and that their efforts to walk in both worlds contribute to their stress.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *b*) provides detailed information on adapting treatment to specific cultural populations, and, while it is not oriented toward offenders in criminal justice settings, much of what it has to say will apply here as well. There are not, however, many culturally specific programs operating in the criminal justice system, and there also are limited data concerning the benefits of culturally competent services in these settings. This is certainly an area that requires more research.

Longshore and colleagues (1998) have studied treatment motivation among African-American detainees who used drugs and had never been in substance abuse treatment. Of all the factors they studied, “problem recognition” was most clearly associated with motivation for treatment, and that recognition was strongest among those who more strongly endorsed Afrocentric values such as community, spirituality, collective self-esteem, and conventional family roles. Incorporating these values into treatment may therefore improve treatment outcomes. For example, it could be more beneficial to emphasize the prosocial reasons for stopping substance use than the negative effects of continuing use, to include family counseling in treatment, and to view recovery as benefiting the community, not just the individual. Compared to clients in traditional programs, those in Longshore’s culturally congruent treatment were more involved in the experience, were more forthcoming in their self-disclosures, and participated more actively. They also reported more motivation to seek help (Longshore et al. 1998).

The consensus panel recognizes that it is extremely difficult, however, to create a culturally specific program within a prison or

jail given the variety of populations who enter the facility and the need to provide equal levels of treatment for all offenders. Culturally specific programs also require from clients a certain level of commitment to their culture that cannot be assumed for all members of a particular group.

Substance abuse treatment requires two-way communication of vital information including instructions, treatment expectations, personal information, and expressions of emotions. In a criminal justice setting, where the counselor represents the same institutional forces that have convicted and imprisoned the client, the levels of distrust and possibilities for misunderstanding are magnified. While all correctional staff members (including counselors) are seen, to some extent, as representatives of the dominant culture, the possibilities for misunderstanding can increase when client and counselor are from different ethnic or cultural backgrounds. These misunderstandings can jeopardize the client's chances for success in treatment. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions that his or her culture has created in matters of communication, therapeutic style, and interpersonal contact and how they affect his or her ability to provide culturally competent services to clients. The most common misunderstandings in counseling originate in culture, socioeconomic class, and language (Sue and Sue 1999). (See the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development b].)

Advice to the Counselor: Culture and the Counselor

- The most common misunderstandings in counseling originate in culture, socioeconomic class, and language. It is the counselor's job to be aware of and sensitive to the values, biases, and assumptions of his or her own culture and to provide culturally competent services to clients.

Women's Treatment Issues

In 1998, an estimated 950,000 women were under supervision by correctional agencies, with 85 percent on probation or parole in the community. These women were mothers to about 1.3 million children under age 18. Forty-four percent of them, across settings, reported that they had been physically or sexually assaulted at some time during their lives (Greenfeld and Snell 1999).

The percentage of women in the criminal justice system has increased in the past decade—in jails it has risen from 10.2 to 11.9 percent (Harrison and Karberg 2002). The average annual percentage increase in State and Federal prisons for women between 1995 and 2003 was 5.0 percent, compared to 3.3 percent for men. In 2003 more than 100,000 women were in State and Federal prisons, and women represented 11.1 percent of adults on parole under State and Federal jurisdiction in 1997 (Harrison and Beck 2004; Maguire and Pastore 2001).

About 60 percent of women in State prisons used drugs in the month prior to the offense for which they were convicted, and about half of these women admitted to daily drug use. Drug use at the time the crime was committed was higher for female inmates than for males (40 percent compared to 32 percent), but more male inmates than females were under the influence of alcohol at the time the crime was committed (Greenfeld and Snell 1999). Interviews with incarcerated women in California, Connecticut, and Florida State prisons indicated that more than 80 percent had used substances regularly during their lifetimes while 71 percent reported regular substance use during the month prior to their most recent arrest (Acoca and Austin 1996). A study conducted by the Connecticut Department of Corrections indicated that 45 percent of female prisoners compared to 22 percent

of male prisoners were in need of substance abuse treatment (Acoca 1998).

Many of the issues discussed in this section apply to male offenders as well as to females but are discussed here because the issues create greater problems for women offenders. (For more on women's treatment issues in general, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT in development g].)

Compared to their male counterparts, female inmates are more likely to have mental disorders (Ditton 1999), to be HIV positive (Maruschak 2004), to have been physically or sexually abused (Harlow 1999), and to have lived with their children in the month prior to their arrest (Mumola 2000). According to Peters and colleagues' (1997) study of women in a Tampa, Florida, jail treatment program, the most common mental disorders that incarcerated women have are serious depression and anxiety disorders. In another study of women in jail awaiting trial, 60 percent were found to have substance abuse or dependence, 22 percent had posttraumatic stress disorder (PTSD), and nearly 14 percent had at least one major depressive episode in the 6 months before entering jail (Teplin et al. 1996). Varese and colleagues (1998) demonstrated that depression among female inmates is greater among women who have deficits in social skills (e.g., are less assertive and/or are more aggressive), have dysfunctional attitudes, and are less able to provide self-reinforcement. These issues must be dealt with in substance abuse treatment programs for incarcerated women because they are intertwined with substance abuse and criminal behavior (Henderson 1998).

Few substance abuse treatment programs have been developed specifically for female offenders, and many of the programs that do exist for women in jails and prisons are based on treatment models developed for male offenders (Peters et al. 1997). However, available research suggests that treatment tailored for female offenders is effective. For example,

an outcome study of Forever Free from Drugs and Crime, a California program created specifically for women offenders, found that the longer an offender remained in Forever Free, the more likely she was to stay out of jail. Women participating in Forever Free come from California State prisons, live in a 240-bed housing unit, and receive treatment four hours per day, five days per week. Counseling addresses issues specific to women, such as dependency, physical and sexual abuse, and parenting. Information on Forever Free is available online at http://www.drugstrategies.org/ks1998/p_crimin.html or through the California Department of Corrections Office of Substance Abuse Programs at (916) 327-3707.

Women in treatment, particularly those in early recovery, need to feel they are in a safe environment, but many do not feel, and some are not, safe in jail or prison (Covington 1998). To try and make the treatment experience feel safer, the harsh confrontational techniques often used in therapeutic communities (TCs) can be modified for women's programs. Instead, a more supportive approach should be used, emphasizing therapeutic sanctions (e.g., participation in treatment activities) rather than punitive consequences (e.g., work assignments) for breaking rules. Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff members as detrimental to their clients' recovery (Welle et al. 1998). Indeed, such staff actions can recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community. Also, rather than needing help in anger management, women are more likely to benefit from learning techniques to reduce "guilt and self-blame, improve self-esteem and self-awareness, and attempt to create an environment of safety and support" (Peugh and Belenko 1999, p. 31). Women are more likely to complete a treatment program designed specifically for women (Roberts and Nishimoto 1996), and clinical experience suggests that women are more likely to disclose personal trauma, such

as sexual abuse and domestic violence, in single-sex groups.

Based on their research with women referred to a jail-based substance abuse treatment program, Peters and colleagues (1997) recommended that programs for female offenders adapt treatment approaches developed for clients with co-occurring disorders (COD). In part, this is because COD are so common in this population, but also because this is one area where more sensitive and flexible clinical approaches have been developed. They stress the need to be flexible in terms of the sequence, focus, and intensity of treatment and to adapt treatment to individual needs wherever possible. They also note that time needs to be set aside for the assessment and diagnosis of COD and for teaching a range of skills (i.e., parenting, nutrition and health care, accessing social services and housing) that are generally not considered as important in treatment programs for male offenders.

Further information on women's treatment issues in general can be found in the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *g*), and more information about treatment for female offenders can be found in Technical Assistance Publication 23, *Substance Abuse Treatment for Women Offenders: A Guide to Promising Practices* (Kassebaum 1999).

Histories of Physical and Sexual Abuse

Histories of abuse are of particular concern for female offenders and can have a significant impact on treatment. (In the general population, about one third of women and between 3 and 24 percent of men have experienced physical or sexual abuse. Among substance using populations, the figures are higher [Gil-Rivas et al. 1997].)

The panel recommends that screening for a history of abuse be included as part of the intake assessments for women in criminal justice treatment settings; to do this, a psychosocial history should be taken that asks about issues such as childhood abuse and domestic violence. One difficulty with addressing these issues with women who are incarcerated is that immediate ongoing counseling is not always possible, given that counseling staff may not be available every day. The consensus panel feels that programs should have aftercare available for clients with histories of abuse. These issues can take a long time to work through and, depending on the setting in which treatment is provided, sufficient time may not be available within the program. Treatment providers should be aware of the range of aftercare options available for clients who are leaving the facility to enter either the community or another facility.

In-depth treatment for the trauma related to a history of abuse should be provided by professionals specifically trained in this area. However, innovative strategies that help women address issues of abuse at a level with which they are comfortable have been developed. For example, the Empowerment through Literacy Project helps women address issues of sexual abuse in a supportive group atmosphere. Women participate in a reading group that facilitates discussions on a number of important issues (e.g., sexual abuse, substance abuse) at the same time it promotes literacy. Readings pertinent to these women's life experiences are selected, including books such as Maya Angelou's *I Know*

Advice to the Counselor: Treating Female Offenders

- Nearly all women's programs consider the use of harsh language, expressions of hostility, and physical force by staff as detrimental to client recovery as these actions recreate abusive interpersonal situations experienced by many of the female offenders while they were in the community.

Why the Caged Bird Sings, Janet Fitch's *White Oleander*, and Elena Diaz Bjorkquist's *Suffer Smoke*.

Under community supervision, an offender's primary goal needs to be to remain drug free and out of trouble, and treatment programs may not have sufficient time or resources to treat all issues that impact their clients. In such cases, however, programs should be prepared to assist clients in finding a suitable treatment program where they can receive treatment for traumatic effects of abuse. Some providers conduct survivors' groups that are geared toward including treatment for trauma issues within substance abuse treatment for women.

In addition to substances, women can also abuse children or even, occasionally, spouses. However, if a cycle of ongoing violence is going to be interrupted, the nature of a woman's crime should not disqualify her for treatment. For example, a woman who is incarcerated for killing an abusive spouse will likely be considered a violent offender and therefore not qualify for treatment.

Two other TIPs are valuable sources of information about treating women with histories of child abuse (TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT 2000d]) and who have been victims of domestic violence (TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997b]). The forthcoming TIP *Substance Abuse and Trauma* (CSAT in development f) also contains useful information.

Low Self-Esteem

Low self-esteem certainly is not just a women's issue. Many offenders, both male and female, experience low self-esteem. Guilt and shame over past actions are often contributing factors to a poor self-image and low self-esteem, but so is a history of discrimination (whether toward the individual or the culture/ethnic group to which he or she belongs) that can produce poor self-esteem

when internalized. Low self-esteem often takes years to produce; it can begin early in life and be increased by physical and sexual abuse, substance abuse, and arrest and incarceration. In order to improve a client's self-esteem, programs need to address this issue continually, affirming at each stage of treatment the client's ability to change and create a positive life.

The strengths-based approach to treatment is widely considered the most effective approach for improving women's self-esteem. The panel also recommends that group work be used with both women and men as a crucial means of building self-esteem. (TIP 41, *Substance Abuse Treatment: Group Therapy* [CSAT 2004], has extensive information on how to conduct a variety of substance abuse treatment groups.) Presenting positive role models to clients also is essential for women (even women who have not gone through the criminal justice system can be role models).

For women, the more time spent in treatment the more likely self-esteem will increase; this increase is most likely if the women are in a residential/inpatient setting. A residential TC helps women build awareness of their strengths and helps them "practice" having higher self-esteem (De Leon and Jainchill 1981). However, if treatment is provided in an outpatient setting, women often return to unhealthy situations (e.g., domestic abuse, a job with low pay and high stress) after their treatment session and their self-esteem will drop again. It takes an extended period of positive reinforcement to raise a client's self-esteem to a level sustainable in the face of oppressive forces. Of course, eventually clients will need to leave a treatment program, but to make that difficult transition as smooth as possible, programs should help the client connect to an appropriate support group.

Parenting and Child Custody

The majority of women imprisoned in jails or prisons are parents and some programs in

and out of prison are adding parenting workshops to their agendas (see text box below). In 1999, more than 1.5 million children had a parent in prison (Mumola 2000; Petersilia 2000), and many more children have had a parent incarcerated during a period of their early lives. At least half of the children of imprisoned mothers have not seen or visited their mothers since incarceration began. Under the Adoption and Safe Families Act of 1997, parents of children in foster care for 15 or more of the past 22 months may have their parental rights terminated by the State. Given that the average prison term for incarcerated women is 15 months (Genty 1998), an increasing number of parents are permanently banned from their children's lives—often a devastating blow for mothers and their children.

Parenting is not just a women's issue, and, in fact, the vast majority (93 percent) of incarcerated parents are male. However, mothers in State and Federal prisons are often (46 percent and 51 percent of the time, respectively) the sole parent living with their children at the time of their incarceration; 31 percent of mothers in prison were the only adult caring for their children before incarceration. Only 28 percent of the children of women in State prisons reside with their other parent and nearly 10 percent live in foster care or an agency. The majority of incarcerated mothers rely on grandparents or other members of their extended family to care for their children while they are incarcerated (Mumola 2000). If a woman is in prison and has no one else to care for her children, her loss of custody could be permanent.

Innovative community reintegration programs for female prisoners may feature eventual reunification with their children as a significant motivator for treatment.

Many incarcerated women feel enormous guilt about being away from their children and worry about maintaining custody of their children (Covington 1998). This guilt may be a motivating force, but it can also overwhelm the client and be a cause for relapse. In some cases, children are used to coerce a parent into treatment; family drug courts, for example, may remove children from a mother's custody if she does not successfully complete treatment. However, the presence of children can be a mother's only link to a stable life, and after losing her children to a Child Protective Services agency or another family member, she sometimes increases her substance abuse.

Research does suggest that it is in the best interest of both mothers and their children to have continued interactions while the woman is incarcerated. Early research by Holt and Miller (1972) found that maintaining family ties and providing parenting training positively affected a parent's success on parole. Stevens and Patton (1998) have found that women in a modified TC that enables them to have their children with them had better treatment outcomes than women who had the same treatment unaccompanied by their children. The panel encourages jail and prison programs to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not

A Program for Paroled Women and Their Children

Walden House opened a residential treatment facility for paroled women and their children in El Monte, California, in 1999 as part of the Female Offender Treatment and Employment Programs (FOTEP). The program is based on the TC model but includes parenting skills, education and vocational preparation, job readiness, job placement, and intensive case management. FOTEP fosters an environment where clients learn new ways of meeting their needs without relying on substances. In addition to its emphasis on obtaining employment, the program includes components for children and models parenting behaviors (Smith 2001).

The DWCF Program for Women and Their Children

DWCF opened in early 1999 to serve the needs of 900 female offenders. In addition to providing treatment for substance abuse and mental health problems, DWCF follows recommended treatment principles for incarcerated women by addressing gender-specific treatment issues such as improving the relationships of mothers and their children and increasing contact between them. All mothers in DWCF participate in a 12-week Parenting Skills Seminar as well as a 12-week seminar that focuses on family relationships (the Family Dynamics Seminar). Among other things, these seminars teach mothers about the importance of regular phone contact with their children to discuss things such as homework, report cards, and special school events. Additionally, the facility has placed special emphasis on increasing the frequency of phone contacts and visits between mothers and children. Visits are encouraged and facilitated by the DWCF staff. Special children's visiting areas have been created; these are painted with motifs from children's literature and furnished with colorful children's furniture, games, books, and toys. The environment is attractive and appealing to children and facilitates positive mother-child interactions. The DWCF administration also has established a collaborative relationship with a Quaker volunteer organization, whose members provide weekly transportation for children (and their caretakers) who lack other means of transportation to the facility. Additionally, the facility has developed several apartments within the prison, permitting weekend visits for mothers and their children during the 4 to 6 weeks prior to the mother's release into the community; these visits help to reconnect mothers and their children during the crucial period just prior to discharge or parole. Staff monitor these visits and provide support and assistance for mothers and their children when needed.

sufficient for mothers or their children. One program that is attempting to increase interactions between incarcerated mothers and their children is located at the Denver Women's Correctional Facility (DWCF) and is described in the box above.

Job Skills Training

As Peugh and Belenko (1999) note, female inmates with substance use disorders have poorer employment histories than their male counterparts, and likely have fewer opportunities for employment (especially at jobs that

pay more than minimum wage) than do men. Vocational training would reduce the need for women to turn to illegal sources of income to support themselves and their families after release (Peugh and Belenko 1999). Therefore, vocational training should be a priority for female offenders in substance abuse treatment; however, this often is not the case. The vocational options available for female inmates are often extremely limited compared to the options available for male offenders. Male offenders have more opportunities to learn higher-paying job skills (such as carpentry or mechanics) than female offenders, and so women too often return to jobs in the community that pay a low wage, do not enable them to support themselves and their children, and do not raise their self-esteem.

The panel recommends that in prisons and jails, substance abuse treatment programs and TCs introduce vocational programs for women and expand

Advice to the Counselor: Parent Training

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the range of vocational skills taught. Programs for offenders under community supervision can obtain access to community vocational programs that will accept their clients. Because so many incarcerated women with substance use disorders have no real employment history or work skills, clients will benefit from learning prevocational skills, earning GEDs, and meeting other educational goals. Counselors can assess both women's vocational interests and their existing work skills. One innovative program that is targeting women with substance use disorders who are serving a prison sentence was developed by the Project for Homemakers in Arizona Seeking Employment (PHASE). A complete description of the program is available online at <http://www.ag.arizona.edu/impacts/2000/ready3.pdf>.

TIP 38, Integrating Substance Abuse Treatment and Vocational Services (CSAT 2000c), provides information on the importance of vocational services, how to integrate them into substance abuse treatment programs, and, in a chapter titled “Working With the Ex-Offender,” specific information on the vocational training needs of offenders.

Men's Treatment Issues

Because men make up the vast majority of offenders and because gender bias often makes people see men's treatment as the norm, it sometimes is difficult to see how certain issues need to be addressed for men in substance abuse treatment programs. Typically, these are issues that have been thought of as women's issues (e.g., sexual abuse, parenting) but also can include issues that are significant for men in the general population, but often forgotten for offenders (e.g., status). Much of the information presented above also applies to men. For more information on men's issues related to substance abuse treatment, see the forthcoming *TIP Substance Abuse Treatment and Men's Issues (CSAT in development e)*.

Fathering

Male offenders often are very concerned about the welfare of their children, although socially defined gender roles still put more pressure on women to be good parents. Male offenders may not talk as much about their children or the feelings they have for them, but they often keep pictures of them and, if asked about them, express concern.

According to Mumola (2000), 40 percent of fathers in State prison had at least weekly contact with their children.

It is particularly difficult for male offenders to admit that they failed as fathers. Being a good father is not, as some might expect, looked down on in prisons as a sign of “weakness,” but rather is generally perceived as an important and valuable activity. However, an individual perhaps feels a conflict between his role as a caring parent and the role of a “hardened criminal” that he presents within the prison.

Many male offenders feel inadequate when dealing with their children and have never had any instruction or assistance in how to be a good father. Their own fathers often were poor role models, and some were (and may still be) incarcerated themselves, even in the same prison. This does not mean, however, that they are bad fathers—just that they are not aware of what they should be doing or how well they are doing in that role.

According to Landreth and Lobaugh (1998), at the end of a parent training class a group of incarcerated fathers was more accepting of their children, perceived fewer problems with their children, and had less stress about parenting compared with offenders who did not participate. The children benefited as well from the structured play therapy, as their self-concept scores improved significantly.

Parent training can also serve as a bridge to counseling. Few criminal justice clients want their children to wind up in prison.

Discussions of parenting and the welfare of one's children often promote strong emotional explorations and counseling opportunities.

Offenders are sometimes more receptive to treatment, and more willing to accept pro-social values, when the appeal is made for the sake of their children.

Developing Relationships

Learning how to relate to people and build relationships (including how to be a friend) takes a lot of work for men. In many cases, this is not a matter of rehabilitation but rather habilitation; some male offenders do not understand how to be a friend, family member, or significant other. They often experience great difficulty even talking about this issue, in spite of the fact that they want to learn these skills. One of the attractions of gang participation is that it gives members a sense of belonging and a certainty about their relationships with one another that they do not have outside the gang. Thus, treatment should encourage men to form relationships based on a shared experience with recovery. Relationship training also is important for job success. Learning how to communicate with peers and supervisors is necessary for maintaining employment and advancement.

Working With Violent Offenders

While substance abuse treatment providers working in any setting may need to discuss violence in a client's past, this issue is especially important when working in the criminal justice system because offenders' violence often has led to their arrest and conviction. Clinicians also must be aware of the possibility that violence could erupt in the treatment program and should pay careful attention to issues that could trigger violence between offenders.

Relationship Between Substance Abuse and Violence

Literature on the subject generally concludes that substance use often is a cause of or a predisposing factor for violence (Friedman

1998). Alcohol is the most frequently used substance that can precipitate violent crime. According to victim reports, perpetrators were clearly under the influence of alcohol in nearly 35 percent of violent crimes; two-thirds of victims who suffered violence caused by a current or former spouse or partner also reported that alcohol was a factor in the incident (Greenfeld 1998). In a 1997 survey, 41.7 percent of State prison inmates and 24.5 percent of Federal inmates convicted of a violent crime reported that they were under the influence of alcohol at the time they committed the crime for which they were convicted; 29 percent of State and 24.5 percent of Federal inmates reported that they were under the influence of drugs at the time (Mumola 1999).

There is some evidence that cocaine, amphetamines, and possibly other substances also have the potential to stimulate violent acts. The relationship of cocaine to violence is better established for those inner-city residents who predominantly use crack cocaine (Friedman 1998). The possible effect of race, ethnicity, or culture on this relationship has not been studied systematically. Although more research is needed, there is at least some reason to believe that the relationship of drug and alcohol use to violence may be affected by cultural factors as well (Valdez et al. 1997). Earlier substance abuse seems to be associated with subsequent violent behavior for both women and men. The effect of alcohol as a precipitant of violent crime is better established for men than women (Friedman 1998).

The relation between substance use and violence is complicated, and there are many individual and group differences in the way substances are used and how they affect people. Some people may in fact use substances in order to be calmer and less prone to violence; others may use them to forget the guilt associated with past acts of violence, which may then precipitate further acts of violence.

Drugs influence levels of violence in other ways. The business of manufacturing and selling drugs can be very violent, and offenders who have been involved in these activities may have committed violent acts in order to survive and succeed. A study demonstrating that legal prohibitions against the use of alcohol or drugs actually increase the level of violence (and homicide in particular) was published by Miron in 1999.

Managing Violence

Within prison culture, violence is an everyday part of life and inmates may resort to violence in order to protect themselves. The prevalence of violence in the system reduces a client's feeling of safety within the treatment setting. Many offenders react with violence because they have never developed the social and coping skills necessary to react to problems in more positive ways. This lack of skills is even more prevalent in offenders with extensive histories of substance abuse. Interpersonal violence is also associated with methamphetamine abuse (Cohen et al. 2003). The prison culture reinforces violent behavior. Individuals who are incarcerated without a history of violence quickly learn its value in jail or prison. Past violence is an issue particularly for offenders who are making the transition from incarceration to the community because past actions may come back to "haunt" them. It can be difficult to find treatment programs in the community that will accept violent offenders.

A number of programs have been developed to help offenders stop violent behaviors. Many of these programs use variations on cognitive-behavioral therapy (CBT) and ask offenders to look at their "criminal thinking" and the ways in which it leads them to commit violent crimes. Several programs have been developed from the model of the Oakland Men's Project, a community-based violence prevention program for men that began in 1979. This project developed a series of workshops that use role-playing exercises to help men understand how society pressures them

to commit (and rewards them for) violent actions.

Programs such as the Violence Interruption Process (VIP) of the Illinois TASC (Treatment Alternatives for Special Clients) and the Ohio Department of Alcohol and Drug Addiction Service's (ODADAS) Ohio Violence Prevention Process (OVPP) were developed from the Oakland Men's Project model.

Illinois's VIP works on the assumption that violent behavior is learned and has an institutional as well as a personal dimension. When people become aware of how they have learned violent attitudes and behaviors, they can learn new methods of communication and resolving conflicts (People for Peace 1996). ODADAS provides onsite trainings in OVPP to substance abuse treatment programs, corrections programs, school systems, and other groups; trainings touch on a variety of issues including the connection between substance abuse and violence, the role of racism and sexism in violence, and building multicultural alliances (ODADAS 2000). More information on promising violence prevention and psychoeducational programs in a range of locales can be found on the Partnership Against Violence Network (Pavnet) Web site (<http://www.padv.org>).

Anger management groups are another useful intervention with this population but the consensus panel recommends that these groups be connected with other interventions and not simply provided as a stand-alone treatment for violent offenders. A variety of curricula are available for running anger management

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groups in jail or community settings. Incentives also are very important when dealing with this population. These are clients who have not had much positive reinforcement in their lives and have grown accustomed to reacting to negative reinforcement with anger and resentment. Head trauma and related brain injury can be another cause of

violent behavior (Diaz 1995; Robinson and Kelley 2000).

In some cases, medication may be called for in order to manage aggressive behaviors (Lavine 1997). When medical, psychiatric, and substance abuse assessments indicate that a client's aggressiveness is not under control, pharmacological treatment sometimes is considered.

People with substance use disorders may experience a coexisting cognitive or physical disability.

Treatment Issues Based on Client's Sexual Orientation

Sexual orientation and sexual behavior are not necessarily congruent, especially within a prison or jail. Many offenders who engage in homosexual activity while in jail or prison do not self-identify as gay, lesbian, or bisexual. Others, who may recognize that they are gay, lesbian, or bisexual, do not openly proclaim that fact (i.e., are not "out") in an incarcerated setting because they fear reprisals. The institutional culture of men's jails and prisons may recognize only the "passive" or receiving sexual partner as gay, which supports a heterosexual self-identification for some men who engage in homosexual activity.

Incarcerated individuals may engage in sexual activity with members of the same gender for many reasons, not all of which reflect their sexual identity. Self-identified heterosexuals may engage in prostitution for money or have sex in order to gain the protection they need to survive within the jail or prison. For such individuals, sexual identity can become an especially important issue upon release as they try to understand their sexual activity and how it relates to their identity and sexual identification. There may be, in fact, men within the prison system who have had more sex with men than women but who still identify as heterosexual. These individuals may face particular difficulties when they return to sex with female partners and may use substances in order to facilitate heterosexual activity.

Reliable data on the prevalence of homosexual behavior in jails and prisons are limited. In one study of a low-medium-security prison, which claimed to underreport some types of sexual behavior, 55 percent of self-identified heterosexuals reported being involved in sexual activity in prison (Donaldson 1990). Despite disciplinary codes in jails and prisons that prohibit all sexual activity, such behavior still occurs. Within men's prisons there is a social hierarchy based on sexual roles. 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. Relationships between inmates imply obligations by each partner: the dominant partner to defend his partner physically against mistreatment by others and the receptive partner to obey the other (Donaldson 1990).

In a study of homosexual behavior in prison, Alarid (2000) surveyed men incarcerated in a county jail who had requested and received protective custody because of their sexual orientation. The gay and bisexual men in the group tended to be older and never married.

Nearly half were African American. Slightly more than half of the men in this study self-identified as bisexual, with one third of those preferring female partners (bisexual/heterosexual). Gay and bisexual men were generally satisfied with their sexual orientation. Almost one fourth of the group (a majority of them gay) exchanged sex for money or favors. The bisexual/heterosexual group felt more pressure to have sex and often used it to gain the protection of another inmate. This is perhaps a result of the fact that the group was small in number and that other inmates sought them as sexual partners. Most of the group believed that their fellow jail inmates treated them disrespectfully. Only a few gay inmates and none of the bisexuals felt that jail personnel tolerated gay behavior or gay or bisexual individuals. More than a third of this group feared being raped in prison and believed that having the protection of a heterosexual was the best way to do prison time (Alarid 2000).

In male institutions, individuals who do self-identify as gay are often victims of rape and/or physical violence. They may need to resort to violence to protect themselves or else become a sexual partner of someone who can protect them. However, these are not typically mutual relationships and the gay partner often needs to assume a submissive role that may not be compatible with the sexual role he prefers; gay inmates often wish to distance themselves from these partners upon release.

Many women also face conflicts between sexual orientation and sexual behavior when incarcerated. However, generally, confusion around sexual orientation is not as difficult for women because sexual encounters in prison involve more of a relationship than they do for men; sexual activity is often a part of a nurturing, family relationship (and women often explicitly take on roles as “husbands and wives”). It is assumed that the prevalence of homosexual activity in women’s jails and prisons is similar to that in men’s. In contrast to relationships among men, women establish partnerships voluntarily and con-

sensually. These partnerships are generally respected by other inmates (Donaldson 1990).

Female offenders also seem more accepting of openly lesbian women than their male counterparts are of openly gay men. Overall, lesbian women have an easier time dealing openly with sexuality while incarcerated than gay men. They may develop very close relationships with other women while incarcerated and express regret that the relationship may end after one partner leaves the institution. Some lesbian offenders say that they enjoy the sexual freedom that a prison environment allows them, and, after release, may express a desire to return to a relationship they had while incarcerated.

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 increased substance abuse. For more general information on working with this population, see *A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT 2001).

Treatment Issues Based on the Client’s Cognitive/Learning, Physical, and Sensory Disabilities

People with substance use disorders may experience a coexisting cognitive or physical disability. A study by the New York State Office of Alcoholism and Substance Abuse Services found that more than 22 percent of the clients served by licensed treatment facilities had a co-occurring mental or physical disability (CSAT 1998d). Self-reports from inmates in 1997 indicate that 31 percent of State prisoners and 23 percent of Federal prisoners had learning or speech disabilities, hearing or vision problems, or mental or physical conditions. This includes 108,000 individuals with learning disabilities, 135,000

with physical impairments, 65,000 with hearing problems, and 94,000 with vision problems (Maruschak and Beck 2001).

Evidence suggests that people with cognitive disabilities are disproportionately involved in the criminal justice system (Cockram et al. 1998). Nearly one third of inmates in State prisons and one quarter of those in Federal prisons report having a physical or cognitive disability. These data, derived from self-reports, are likely to underrepresent some conditions, including learning disabilities, of which inmates themselves may not be aware. Ten percent of State and 5 percent of Federal prison inmates report a learning disability. Also, data from inmates in State prisons show that they are three times more likely than the general population to have a speech disability and more than twice as likely to have impaired vision. These inmates are, however, slightly less likely to have a hearing impairment, but this can be accounted for by the age and gender differences from the general population (Maruschak and Beck 2001).

People with cognitive disabilities are at a significant disadvantage in their contacts with the criminal justice system. For example, offenders with developmental challenges are disproportionately likely to be arrested and coerced into a confession for a crime they did not commit. They may not understand their Miranda rights and are eager to please, ignorant of the value of remaining silent, susceptible to leading questions, insensitive to non-verbal cues, and desirous of appearing competent (Cockram et al. 1998). They also are easily led into criminal activity by others, and, in their desire to feel like they belong to a group, they may even view arrest and incarceration as successful achievements (Wood and White 1992). Inside jails and prisons, they tend to be victimized by other inmates, and often try to hide the presence of their disability in order to avoid further victimization. According to focus group interviews with family members of people with cognitive disabilities, one way the criminal justice system could better assist people with cognitive disabilities

is to provide qualified staff members to work with them in the early stages of the legal process (Cockram et al. 1998).

Jails and prisons can be difficult places for people with physical disabilities (e.g., there may be no wheelchair access and bathrooms may not be fitted with hand rails). Sometimes clients with disabilities can be moved to other facilities that are not necessarily appropriate for them, given their sentence (e.g., they may be moved to a medium security facility even though their sentence warrants maximum security). In June 1998, the U.S. Supreme Court ruled that State prisons must comply with the provisions of the Americans with Disabilities Act. This means that they must make reasonable accommodations to provide access to basic facilities and services for eligible prisoners with disabilities (American Civil Liberties Union 1998).

Certain physical disabilities require medication, and this can pose particular problems for treatment facilities in jails and prisons. Facilities may need to give offenders medications at specific times that could conflict with other scheduled activities. Clients under community supervision require a support system that can help them manage their medication and oversee compliance.

Clients who have conditions such as diabetes that require the administration of medication by means of a syringe may face daily 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 looking at these triggers and developing a relapse prevention plan that addresses them. For example, individuals who need to administer medications using a syringe who are no longer in a residential program could have a friend or relative available to be with them when they give themselves their shots (at least for the first few months after release). Programs can provide these individuals with a small safe where they can keep needles and should advise them to keep syringes in more

than one place so that if any are stolen they will still be able to administer their medication. Individuals should always check their syringes to see if others have used them and should keep a supply of bleach available to clean needles if they suspect their needles have been used.

Given the prevalence of disabilities in incarcerated populations, especially among offenders with substance use disorders, the consensus panel suggests that treatment providers be able to screen for co-existing disabilities and make accommodations for offenders who have them. For example, someone with mental retardation may not be able to participate in a traditional TC and may need to be sent to a modified TC or have another suitable treatment option available. Information on treatment for clients with co-existing disabilities can be found in TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998d).

Treatment Issues for Older Adults

Age is a factor associated with positive treatment outcomes. The older one is the more likely one is to stay in treatment, complete treatment, and have positive outcomes following treatment. For some older clients the negative consequences of a criminal lifestyle accumulate over time, while the body becomes less capable of managing substance abuse and related stressors, leading to a desire for change. Engaging these individuals in treatment may be relatively easy. However, older offenders also have unique issues that counselors need to be prepared to address. For one, this population is more prone to health problems. Visual impairments and hearing loss are factors, along with chronic health problems, senile dementia, and dementia related to long-term substance abuse. Other characteristics typical of this population that complicate treatment include

- A slow response to directions

- Rigid habits
- The likelihood of a physical condition presenting as an emotional problem
- Lifelong patterns of criminal behavior that cannot easily be altered
- A lack of assertiveness, suggesting that younger, more verbal inmates are more likely to get treatment (Chaiklin 1998)

Readers are referred to TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998c), for more information on substance abuse treatment for this population. See also chapter 9, *Issues Specific to Treatment in Prisons*, for a description of how older inmates can serve an important function in prison-based substance abuse programs.

Age is a factor associated with positive treatment outcomes.

Treatment Issues for Clients From Rural Areas

In the past, alcohol has been the largest substance abuse problem in rural areas, but that is beginning to change. While certain substances of abuse are more available than others, illicit substances are reaching rural communities. There is now no difference in prevalence of illicit drug use between large and small metropolitan areas and rural areas with the exception of marijuana (National Center on Addiction and Substance Abuse [CASA] 2000). In an evaluation of substance abuse in rural Nebraska, marijuana was found to be the most common drug (as it was in urban areas), but methamphetamine abuse was more common than cocaine abuse; those

who abused substances tended to be younger than those in urban Nebraska and were more likely to be involved in the selling of drugs (Herz 2000). However, these patterns vary by region; for example, in rural northern Louisiana, cocaine abuse predominates and methamphetamine abuse does not seem to be a significant problem (Monroe 1998). Abuse of OxyContin has been more common in several rural areas, such as the eastern Kentucky and western Virginia areas of Appalachia.

Clients from rural communities have distinct cultures that differ from region to region. Treatment staff working with clients from a particular rural population should seek to understand that culture in the same way they would any other. Increasingly, offenders from urban areas are being sent to prisons located in rural regions and staffed by local residents; here again, a cultural clash can develop, and training can help staff understand the cultural background of offenders coming from urban areas.

Services available in rural areas may also be more limited than those in more densely populated regions. A rural jail, for example, is generally unable to develop a substance abuse treatment program because its resources are limited. Community supervision programs in rural areas also have particular difficulties. Few programs will be available, there is little coordination between programs, 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.

Advice to the Counselor: **Rural Clients, Rural Counselors**

- Clients from rural communities have distinct cultures that differ from region to region. In addition, more and more offenders from urban areas are being sent to prisons in rural regions with local staff.
- Counselors should seek to understand urban–rural differences in culture as they would any other.

Treatment Issues for People With Co-Occurring Substance Use and Mental Disorders

According to a study conducted in 1998, an estimated 283,800 offenders in jails and prison and another 547,800 on probation reported having a mental disorder and/or had stayed overnight in a mental hospital (Ditton 1999). Reported mental disorder varied across setting, with 16.2 percent of inmates in State prison, more than 7 percent of Federal prison inmates, 16 percent of jail inmates, and 16 percent of probationers reporting mental disorders or a stay in a mental hospital. Rates were substantially higher for women than men and for Caucasians than African Americans or Hispanics/Latinos. Individuals with mental disorders were more likely to have been under the influence of substances at the time of their offense and substantially more likely to report a history of substance abuse than others (Ditton 1999). The National GAINS Center, a Substance Abuse and Mental Health Services Administration (SAMHSA) initiative to study mental health and substance abuse services for people in the criminal justice system, estimates that of jail inmates identified with mental illness, 64.3 percent reported alcohol or drug use at the time of the offense. Among the State prison population the figure is 58.7 percent (National GAINS Center 1997).

Even conservative estimates report high rates of mental disorders. Ditton (1999) reports that three previous studies of inmates in jail or State prison with rigorous sampling methods found rates of mental disorders to be between 8 and 16 percent. A study of incarcerated women awaiting trial in a Chicago jail found significantly higher rates of mental disorders based on offender

reports of psychiatric symptoms; 18.5 percent of the women had experienced symptoms of a severe disorder (i.e., schizophrenia/schizophreniform, manic episode, major depressive episode) at some point during their lives, 33.5 percent had experienced PTSD, and 70.2 percent had a substance use disorder (Teplin et al. 1996).

More information on the treatment of clients with COD can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005c).

Identifying Co-Occurring Disorders

There is a great deal of stigma associated with mental disorders even within the culture of prisons and jails. At the same time, in correctional institutions, substance abuse does not carry the same degree of stigma as it does in the outside community. In some prison settings, procedures such as public medication lines expose the inmate with a mental disorder to public ridicule, adding to the stigma and reinforcing the inmate's reluctance to admit to his or her disorder. Offenders may be willing and able to face talking about their criminal activity or substance abuse but reluctant to discuss their mental disorder. Consequently, actual rates of mental disorders in this population are likely to be higher than self-reported rates.

Because one disorder can mask or imitate the other, accurate diagnosis of COD requires skilled screening and assessment. Assessment should look for both problems at the same time, rather than separating assessments for mental disorders and substance abuse. Regular reassessment is also important. Trained staff should be used to perform such assessments. Most prison programs for inmates with COD do use doctoral-level staff for initial screenings (Edens et al. 1997). For more on screening and assessing for COD, see chapter 2.

Co-Occurring Disorders Treatment Programs

In order to serve the high number of offenders with mental and substance use disorders, a number of diversionary and corrections-based programs have been developed for offenders with COD.

Diversionary programs for offenders with co-occurring disorders

These programs, generally referred to as Mental Health Courts, currently exist in a handful of municipalities across the country (Broner et al. 2002). SAMHSA has funded jail diversion programs at nine sites for offenders with COD. In the Eugene, Oregon, program, for example, mental health and substance abuse treatment is collaborative; sanctions applied are sensitive to mental health problems and the case manager is a mental health specialist who acts as court liaison (National GAINS Center 1999b).

Prison- and jail-based programs for offenders with co-occurring disorders

In addition to diversion programs such as mental health courts, there has been a rapid growth in corrections-based co-occurring programs during recent years, from only 2 State systems that had developed these programs in 1993, to 7 systems with programs in 1997, to 18 systems in 2002 (Edens et al. 1997). However, few State systems have systematic procedures for identifying and tracking prison inmates with COD. Moreover, little research has yet been done on the effectiveness of these programs. Preliminary outcome data from one study comparing a modified therapeutic community (MTC) program for prison inmates with COD with treatment as usual and with a mental health group showed the MTC group to have fewer new arrests,

less use of illicit drugs, and better compliance with treatment regimens (Sacks et al. 2001).

Several features distinguish the programs that treat inmates with COD from other criminal justice substance abuse treatment programs:

- *An integrated treatment approach is used whenever possible.* Mental health treatment staff, substance abuse treatment staff, and criminal justice staff are located in the same program unit, and often share in decision-making. In some jurisdictions, both correctional officers and community supervision officers have been successfully involved in treatment team meetings, treatment groups, and other therapeutic activities. A wide range of treatment approaches are implemented, according to the client's stage of treatment. Collaboration and/or consultation may be adequate to serve offenders who have less severe COD.
- *Both disorders are treated as "primary."* Integrated treatment involves simultaneous consideration of both disorders and attention to the interactive nature of these disorders. However, the scope and intensity of treatment activities will vary according to the client's needs and functioning level.
- *Comprehensive treatment services are flexible and individualized.* Treatment should be adapted to address different levels of symptom severity, functioning, and commitment to treatment. Both early intervention and active treatment interventions should be adapted for different diagnostic groups and for offenders with special needs (e.g., those with cognitive impairment, women with trauma and abuse histories).
- *Treatment approaches that are commonly used in substance abuse treatment settings (e.g., TCs, cognitive-behavioral treatments, relapse prevention, peer and alumni support groups) are adapted to better suit the needs of offenders with COD.* Common modifications include smaller caseloads, shorter and simplified meetings, special attention to criminal thinking, education about medication, and minimizing con-

frontation (Edens et al. 1997; Peters and Hills 1997).

- *Treatment is provided in graduated "phases" or "stages," using a highly structured psychoeducational treatment approach.* Early phases of treatment include a focus on orientation, assessment, development of treatment plans, and engagement and persuasion activities. Didactic approaches are particularly useful in early stages of treatment to help offenders understand the nature of their mental disorders and biological aspects of both disorders. Secondary phases focus more on "active treatment," such as development of coping and life skills, lifestyle change, and cognitive-behavioral interventions. Later phases may include relapse prevention, peer mentor activities, vocational training, reentry planning, and linkage with community support and treatment programs. Case management and relapse prevention activities often are provided throughout the various phases of treatment, with a particular emphasis during prerelease and reentry phases. In jails, where the relatively brief period of incarceration may prevent the use of a long-term phased treatment approach, services may focus on assessment, brief psychoeducational interventions, community "in-reach" services, and linkage to community services.
- *The focus of treatment is long term, with an emphasis placed on continuity of treatment in aftercare and postrelease settings.* Recovery and stabilization for offenders with COD often occurs over a period of several years and includes multiple treatment episodes. COD treatment programs should provide linkage with other community treatment and ancillary service providers, and should develop detailed aftercare, transition, and postrelease plans to ensure continuity of services. These should include provisions to furnish an adequate supply of psychotropic medications for the offender during transition from institutional to community programs. The offender also should be monitored carefully during transition periods, when stress levels are high and

there is increased risk for recurrence of mental health symptoms, substance abuse relapse, and recidivism. Forensic coordinators or other case managers have been used successfully in some jurisdictions to help in community transition.

- *Staff are trained and experienced in treating both mental disorders and substance abuse.* A blend of staff experience is needed, including those trained in working with acute symptoms of mental disorders and those who have worked in specialized substance abuse treatment settings, such as TCs. Cross-training activities are useful to share information from the perspectives of each of the treatment disciplines, and also from the perspective of security/community supervision.

Programs for offenders with co-occurring disorders under community supervision

This group of offenders will have particular difficulties finding aftercare programs to accept them because of the stigma associated with the combined problems of COD and a criminal record. Nor will most traditional community mental health interventions be effective for them, as they typically have complex problems that require specialized treatment (Broner et al. 2002). Community supervision of offenders with COD also requires specialized strategies (Peters and Hills 1997), including

- Recognition of special service needs
- Use of supportive rather than confrontational approaches
- Positive reinforcement for small successes and progress
- Different expectations regarding response to supervision
- Flexible responses to infractions
- Use of concrete directions
- Highly structured activities
- Ongoing monitoring

- Enlistment of support from family members to work with offenders with COD where appropriate
- Close coordination between the community supervision/probation officer and the offender's clinician

Medication Management

Substance abuse treatment providers working with people with COD need to understand and be able to help educate clients about the importance of medication management and compliance. Clients sometimes have trouble distinguishing between “good” and “bad” drugs, particularly at the beginning of treatment. The distinction is made more difficult by the fact that the “good” medications are more expensive and more difficult to obtain than illicit drugs. There still is a myth within the substance abuse treatment field that use of psychotropic medication by individuals with co-occurring mental disorders should be discouraged. Programs in criminal justice settings should update their formulary so that they are using the most up-to-date medications. Offenders entering jails may have particular problems around medications because they may not be able to receive necessary medication while incarcerated or may not be given a supply of medication upon discharge (which they might need until they can get prescriptions filled). It often takes well over a month to be seen by a psychiatrist and to receive a prescription for medication. In addition, certain medications (e.g., antidepressants) take several weeks to build up to effective levels in the bloodstream. Moreover,

Advice to the Counselor: “Good” and “Bad” Drugs

- Clients with COD need help with medication management, especially in distinguishing between substances of abuse and licit medication.
- Counselors must be alert to inmates who skillfully mimic the symptoms of mental disorders in order to receive medications.

individuals often do not have enough money to pay for the medication. The consensus panel suggests that programs working with people who are making a transition from institution to community need to ensure that these clients have an adequate supply of psychotropic medications.

On the other hand some inmates can skillfully manipulate signs and symptoms of mental disorders in order to receive medications with sedative properties. Some of these medications (such as benzodiazepines, prior-generation antidepressants, and antipsychotics) can have serious and severe side effects. These medications can be sold to other inmates or exchanged for favors.

Case Management Services

Case management services are useful in providing access to a broad range of mental health and substance abuse services and are complementary to a range of other treatment approaches used with offenders with COD. Research indicates that case management services can lead to improvement in a client's functional status and fewer hospitalizations during an extended followup period (Mueser et al. 1997). One model is Intensive Case Management (ICM). ICM is provided by multidisciplinary teams that include mental health treatment staff, substance abuse specialists, housing specialists, and community supervision officers. These teams often share caseloads to provide flexibility in coverage. Participation in treatment is provided through crisis and outreach services, use of specialized engagement and motivational strategies, and culturally relevant programming over an extended period of time.

Services provided by case managers are developed to address the stage of COD treatment (Lurigio 2000b). This includes an early emphasis on client engagement and commitment to the recovery process, and is followed by persuasion to consider abstinence and to begin active behavior change. Later stages of treatment include the use of cognitive-behavioral

interventions, development of a drug-free social support network, understanding of relapse risks, and use of relapse prevention skills. Another frequently employed case management approach for use with COD is the Assertive Community Treatment model (ACT) (Brown 2003; Stein and Test 1980). Key elements of this approach include crisis intervention, supportive therapy, substance abuse counseling, skills training, medication monitoring, housing support, vocational rehabilitation, specialized dual diagnosis groups, family psychoeducational groups, and family outreach activities.

Special Considerations in Treating Antisocial Personality Disorder (ASPD)

Substance abuse often is associated with criminal or antisocial lifestyle and is highly correlated with ASPD (Knop et al. 1998; Robins and Regier 1991). Someone with ASPD does not accept society's values or norms and acts without guilt; he sees other people as objects to meet his needs. According to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), ASPD "is a pattern of disregard for, and violation of, the rights of others" (American Psychiatric Association [APA] 1994, p. 645). In order to be diagnosed with ASPD, a person needs to demonstrate, after the age of 15, three or more of the associated traits. (See Figure 6-1 for list of traits.) Given these criteria it is easy to see why offenders who abuse substances often are diagnosed with ASPD. In a sample of 325 psychiatric patients who had recently been hospitalized, Mueser and colleagues (2000) found that both a history of incarceration and ASPD were predictive of substance use disorders. In another study that looked at clients in substance abuse treatment, Compton and colleagues (2000) found that 44 percent qualified for ASPD at some time during their life. Research from a male prison TC found 52 percent of clients had ASPD (Wexler and Graham 1993).

Figure 6-1
Traits of ASPD (DSM-IV)

- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Irritability and aggressiveness, as indicated by repeated physical fights and assaults
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Impulsivity or failure to plan ahead
- Reckless disregard for safety of self or others
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Source: Hare et al. 1991.

While it is generally believed that ASPD is more common in men than women, available data are mixed. Researchers studying people in psychiatric hospitals (Grilo et al. 1996), in treatment programs for alcoholism (Cornelius et al. 1995), and in homeless populations (North et al. 2004) have found significantly higher rates of ASPD for men than for women. Galen and colleagues (2000), however, found prevalence rates of 16 percent for men and 22 percent for women in a group of 235 clients at outpatient substance abuse treatment centers. Rates are high for offenders of both genders. A study of women entering prison in North Carolina found that rates of ASPD were significantly higher than for women in the general population (Jordan et al. 1996), and Teplin and colleagues (1996) in their study of women in Cook County, Illinois, jails found that 13.7 percent met DSM-III-R criteria for ASPD within the 6 months prior to their incarceration.

The panel cautions that some people who meet the criteria for ASPD do not really have the disorder—their behaviors are the result of other factors, most notably substance abuse. The behavior of these clients is improved greatly after treatment. It is not easy, though, to determine who really does have ASPD and who does not. There also are

people who have ASPD but who lie about behaviors that qualify for this diagnosis.

Psychopathy is a term used to describe a more extreme form of ASPD. In addition to the criminal tendencies apparent in ASPD, people with psychopathy also exhibit affective and interpersonal dysfunction (Hare et al. 1991). Moreover, offenders who score high on the PLC-R (the test for psychopathy; see chapter 2 for more information) have higher rates of recidivism and are more prone to violence both in and out of criminal institutions (Hare et al. 1991).

ASPD and psychopathy are difficult to treat and in this regard are addressed somewhat differently from other mental disorders. Approaches used for offenders with ASPD and psychopathy are typically focused on behavior management rather than on counseling or other therapeutic techniques. These approaches involve heightened accountability (i.e., surveillance and monitoring), highly structured programming, and application of carefully crafted sanctions and incentives for targeted behaviors.

People with severe ASPD require intensive, long-term residential treatment for their disorder and for substance abuse; if they interrupt treatment they are likely to return to

previous behaviors. It should be noted, however, that about half of all people with ASPD display fewer antisocial behaviors as they grow older, beginning in their 40s or 50s (APA 1994). More information on the treatment of clients with COD can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005c).

Special Considerations in Treating Borderline Personality Disorder (BPD)

According to the DSM-IV, borderline personality disorder is characterized by “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (APA 1994, p. 654). It can include recurrent suicidal or self-harming behavior, intense anger or inability to control anger, and stress-related, psychotic-like symptoms (see Figure 6-2, below). Women are three times more likely than men to be diagnosed as having BPD (APA 1994).

Treating offenders with BPD requires great care due to their emotional instability, tendency toward violence, and risk for self-destructive or suicidal behavior. Moreover, because of their tendency to idealize counselors, the therapeutic relationship is likely to be intense, and the offender with BPD is likely to have strong reactions to the counselor. The American Psychiatric Association recommends that treatment for people with BPD take into account these special features:

- *Co-occurring disorders.* In addition to substance use disorders, mood disorders, eating disorders (especially bulimia), PTSD, anxiety disorders, dissociative identity disorder, and attention deficit/hyperactivity disorder are especially common in people with BPD.
- *Use of alcohol and illicit substances.* People with BPD rarely are forthcoming about their use of alcohol and illicit substances. Counselors should inquire specifically about substance use from the beginning, and continue to educate clients about the dangers of substance use.

Figure 6-2
Borderline Personality Disorder

People diagnosed with BPD must have five or more of the following behaviors:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance or markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior or gestures, or self-mutilating behavior
- Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- Transient, stress-related paranoid ideation or severe dissociative symptoms

Source: APA 2000.

- **Violent behavior and antisocial traits.** Treatment courses will vary according to the degree of violent or antisocial behavior. In mild cases (e.g., shoplifting), cognitive therapy is recommended. For more severe cases, residential treatment (e.g., a TC) may be effective. Episodic violence may benefit from the use of mood-stabilizing medication. For severe antisocial features, hospitalization may be required.
- **Self-destructive behavior.** Addressing self-destructive behavior is a primary part of treating BPD. Behaviors such as self-mutilation, suicide attempts, risky sexual behavior, and reckless driving are immediate threats to the individual and should be given treatment priority. Helping clients to think through the consequences of destructive behavior can be of use.
- **Childhood trauma and PTSD.** While not universal, childhood trauma is very common among people with BPD. Treating offenders with BPD will often entail addressing the trauma and symptoms of PTSD.
- **Dissociative symptoms.** Because there often is comorbidity between BPD and dissociative disorders, counselors must also be aware of the likelihood that the offender with BPD experiences transient dissociative symptoms (e.g., depersonalization, derealization, and loss of reality testing), and/or dissociative identity disorder. Counselors can assist by exploring the extent of the dissociative symptoms, the current issues that may lead to dissociative episodes, and the nature of dissociative symptoms. It may also be helpful to teach clients how to control dissociation and to work through post-traumatic symptoms.
- **Psychosocial stressors.** Stress can heighten the symptoms of BPD, trigger relapse, and undermine recovery. Moreover, because of their intense fear of abandonment, many clients with BPD will be sensitive to any perceived rejection within any relationship, including the client–counselor relationship. Counselors should thus be watchful of reac-

tive behavior that often results when the offender feels in danger of being abandoned.

A general clinical observation is that the TC is an effective treatment for both ASPD and BPD through the emphasis on interventions that facilitate socialization and maturity.

Special Considerations in Treating Depressive and Bipolar Disorders

Treatment strategies for offenders with co-occurring major depressive disorders have focused on modifying thoughts that lead to depression or that are related to substance abuse. Issues surrounding loss and trauma are typically addressed when an offender is able to tolerate uncomfortable mood states without turning to substance abuse. Activities are designed to promote understanding of how trauma and abuse experiences are expressed through emotions, physical reactions, and behaviors, including substance abuse. In addition to the interventions for depressive disorders, treatment for offenders with bipolar disorders addresses impaired judgment that occurs during manic episodes, and the effects of substance abuse on judgment. Treatment strategies often focus on building an acceptable set of coping responses to manic or hypomanic impulses, as well as medication adherence when warranted.

Special Considerations in Treating Schizophrenia/ Psychotic Disorders

Treatment for offenders with co-occurring psychotic disorders is designed to address disorganized thought patterns and communication style. Specialized approaches used in treatment include use of concrete concepts, avoiding harsh confrontation, and greater use of structured exercises and written materials.

Offenders who have psychotic disorders often abuse substances for many of the same reasons as other individuals. Key treatment components include education in drug refusal skills, identification of strategies to fight boredom, building supportive social networks, and medication adherence.

Special Considerations in Treating Attention Deficit/Hyperactivity and Other Cognitive Disorders

Interventions for offenders with co-occurring attention deficit/hyperactivity disorder (AD/HD) focus on interpersonal difficulties, social skill deficits, and cognitive skill-building to address impulsiveness and aggression. Information should be conveyed visually as well as orally when possible. Short therapeutic sessions provided in environments that have few distractions are preferable. With this population it is particularly important to repeat important themes and to rehearse key skills in various settings. Those with cognitive disorders need concrete, practical information and skills. (See also TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* [CSAT 1998d].)

Special Considerations in Treating PTSD, Phobias, and Other Anxiety Disorders

Treatment of co-occurring anxiety disorders focuses on interventions to improve social skills and to modify cognitions associated with difficult interpersonal situations, particularly those that augment anxiety. It is particularly important in treating clients with anxiety disorders for the counselor to be calm and reassuring. Clients with PTSD often make slow progress in achieving the trust necessary in a therapeutic alliance. It is important not to encourage discussion of traumatic events, particularly early in treatment. Those whose trauma-related symptoms are severe can ben-

efit from learning techniques to help them focus on staying in the “here-and-now.” Recovery from PTSD often requires long-term treatment from specially trained clinicians. Counselors should be prepared to refer these clients to trauma experts. (See also the forthcoming TIP *Substance Abuse and Trauma* [CSAT in development f].) Clients with phobias can be especially sensitive to social situations and may need help in participating in mutual self-help groups. Specialized approaches, including use of medications, to reduce anxiety-induced insomnia also may be indicated.

People With Infectious Diseases

HIV, AIDS, and tuberculosis are more prevalent among inmates than in the general population. At the end of 2002, 2 percent of all inmates in State and 1.1 percent of all inmates in Federal prisons were known to be infected with the HIV virus. Rates of HIV infection were higher (3 percent) for female inmates of State prisons than for males (1.9 percent) (Maruschak 2004). In 2002 they were also higher for African-American (1.2 percent) and Hispanic/Latino (2.9 percent) jail inmates than for white jail inmates (.8 percent) (Maruschak 2004). More than a quarter of all inmates known to be HIV-positive in 2002 were held in New York State, amounting to 7.5 percent of that State’s total prison population (Maruschak 2004). According to 2002 data, 0.50 percent of inmates in State prison had confirmed cases of AIDS, three and one-half times the rate for the general population (Maruschak 2004).

Evidence suggests that sexually transmitted diseases (STDs), hepatitis B and C, and tuberculosis also affect inmates disproportionately (Hammet 1998; Hammet et al. 1999; Varghese and Fields 1999). Routine screening for STDs and hepatitis is not included in many correctional systems, and, although HIV prevention programs are becoming more common, few correctional systems have

implemented systemwide programs to educate inmates about these diseases or to institute preventive measures. High-risk behaviors for the spread of HIV occur with great frequency in correctional facilities. These include unprotected sexual activity, substance use, and tattooing. The data clearly show that there is transmission of HIV between inmates (Hammett et al. 1999). Curricula for HIV prevention are available in many prisons. However, although female inmates have higher rates of HIV than their male counterparts, few HIV educational programs have been developed for the particular needs of women.

The Federal prison system undertakes random HIV testing of inmates for data collection purposes, and all inmates are tested on release; otherwise inmates are tested only if there is a clinical indication that they may be HIV-positive or if they request testing. States have various procedures for testing the HIV status of inmates. Some States test all inmates who meet the criteria for belonging to a high-risk group, some test everyone entering the facility, and still others test inmates upon discharge from the facility. More information on substance abuse treatment for people with HIV/AIDS can be found in TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000e).

Project ARRIVE

Project ARRIVE, a NIDA-funded AIDS prevention training model, was designed specifically for recently released parolees with histories of intravenous drug use—a population particularly vulnerable to resuming high-risk behaviors (Wexler et al. 1994). ARRIVE’s assumption was that reinforcing parolees’ general social and personal rehabilitation could reduce the risk of contracting AIDS. The program incorporated the principles and techniques found to be useful for treating those with substance use disorders in other settings.

- *Social learning approach to prevention training.* The training program emphasized learning skills to resist relapse and develop personal and social competencies (Botvin et al. 1984) and included rational decisionmaking, coping with anxiety, assertiveness, and relaxation skills.
- *A strong self-help orientation.* Participants were encouraged to accept responsibility for their behavior; to develop their capacity to change negative features of their daily lives; and to engender a sense of mutuality, trust, and honesty among participants (Gartner and Riessman 1977).
- *Use of principles effective in TC programs* (De Leon 1999, 2000; DeLeon and Ziegenfuss 1986). Some ARRIVE training staff were themselves in recovery and could function as role models. In addition, the program fostered the development of peer support networks. Graduates were encouraged to continue their association with the program through weekly aftercare groups.
- *Job readiness preparation and placement assistance.*

These elements were combined into a structured 8-week, 24-session AIDS prevention program. Each new class met for 2 hours a night, three times per week over an 8-week period. Participants received \$10 per session for a total of up to \$240 if they attended all 24 sessions. Trainees also were given two subway tokens per session. ARRIVE participants were offered confidential HIV testing and counseling.

During the NIDA study, a total of 394 eligible parolees were recruited, of whom 241 (61 percent) attended the Training Program, including 164 program completers, for a 68 percent graduation rate. (During the second half of the program, 81 percent graduated.) The outcome evaluation, conducted 1 year after study recruitment, compared program graduates with parolees who never attended, controlling for observed group differences at baseline. ARRIVE participation significantly decreased most sexual and some drug-related risk behaviors and improved parolees’ community adjustment during the followup period (Wexler et al. 1994).

While HIV/AIDS is widely recognized as a serious and significant problem within prisons, other infectious diseases are not always given the same attention. A vaccine is available for hepatitis B that could control the spread of that disease. However, the prevalence of hepatitis C virus (HCV) is increasing. In California, 41 percent of incoming prisoners were positive for HCV in 1994.

Prevalence rates among HIV-positive offenders are higher (Hammett et al. 1999). Because the incubation period is so long (approximately 20 years), many offenders who have the disease will not experience its effects until after they are released. Consequently, not all prison systems recognize hepatitis C as a problem; nor do they expend costly resources on its treatment. Rates of tuberculosis (TB) have declined since 1991 both in the general population and among incarcerated offenders, although they are still higher among inmates. Not all systems routinely screen for TB and report results. There is a risk to correctional employees of contracting TB due to insufficient control measures (Hammett et al. 1999).

Medical Care

Research indicates that medical care for offenders in the criminal justice system is inadequate and underfunded, and the burden is increasing as the inmate population ages. This exacerbates poor health habits and neglect of health care not uncommon among

people who come in contact with the criminal justice system. Medical care is extremely important for offenders with substance use disorders, who often have a number of medical problems. While using alcohol and illicit drugs, offenders often ignore their health problems. When they finally enter treatment they could have several problems that have been untreated except for self-medication. If they are in pain they are less able to focus on their substance abuse treatment. As a consequence, substance abuse treatment staff often request that the institution pay greater attention to medical issues and advocate for medical services for their clients.

Substance abuse treatment staff also should stress the importance of good health when working with offenders. Health improvement can be included as a goal for clients and written into their treatment plans.

Prevention and Education

Educational programs about infectious diseases are a useful addition to a treatment program but cannot stand alone without counseling and treatment for those diseases. Simply informing a group of offenders about the dangers of infectious disease without helping them deal with the possibility of infection can actually cause additional problems, such as fights caused by fears of infection. Prevention and testing efforts often work more smoothly if integrated into a substance abuse treatment program, as counseling staff can work with an individual and help him or her deal with concerns and fears. Programs can use peers who are HIV-positive to provide education to other offenders; in addition to providing other offenders with information from a credible source, peer education helps the person who is HIV-positive feel that his or her life has some sense of purpose.

Advice to the Counselor: Infectious Diseases

- Education about infectious diseases such as HIV/AIDS and hepatitis C is a useful addition to a treatment program. However, this education must take care not to cause additional problems such as fights over fear of infection.
- Counseling by peers who are HIV-positive provides information from a credible source.
- Health improvement can be included as a goal for clients and can be written into their treatment plans.

Sex Offenders

Self reports of those incarcerated for rape or sexual assault reveal that 23 percent admitted they were under the influence of alcohol alone when they committed their crime, another 15 percent acknowledged using both alcohol and drugs, and an additional 5 percent reported they had been using drugs alone (CASA 1999). That even these self-report numbers considerably underestimate the pervasiveness of substance abuse among sex offenders is suggested by the fact that 42 percent of those arrested for sex offenses tested positive for drugs at the time of arrest (CASA 1999). Similar evidence for alcohol use is not available but can be presumed to be considerably higher. Among incarcerated sex offenders, two of every three have a history of alcohol or drug use, abuse, or addiction (Peugh and Belenko 2001).

While the high prevalence of substance abuse among sexual offenders is clear, solid information about the relationship between substance abuse and sexual offending is not readily available. While many convicted sex offenders will admit to problems with alcohol or illicit drugs, it is unusual for someone identified with alcohol or drug problems to freely disclose illegal sexual behavior. The negative consequences of such an admission would usually be too great. Consequently, what is known about the co-occurrences of substance use disorders and the commission of sex offenses comes mainly from the personal history and self reports of identified sex offenders within the criminal justice system and their victims.

Sex offenders apprehended and labeled through the criminal justice system are thought to represent a small portion of those who actually commit sexual offenses (Center for Sex Offender Management 2001a). Only those individuals actually convicted of sexual offenses are likely to be identified as a sex offender subgroup with COD requiring specialized attention. And for this population, the focus of treatment is likely to be the sexu-

ally deviant behavior. Alcohol and drug issues are usually seen as one part of a broad array of problems contributing to the sex offense and specific attention to substance abuse issues may comprise only one of many treatment modules designed to address these underlying problems (Barbaree et al. 1998). Many sex offenders with substance abuse issues are excluded from many substance abuse treatment programs. Analysis of Bureau of Justice Statistics data reveals that 34 percent of sex offenders receive drug treatment in prison, as opposed to 42 percent of other violent offenders (Peugh and Belenko 2001). Often if they are to get any treatment for their substance abuse problems, it must be in or in conjunction with a sex offender treatment program. Otherwise, to participate in substance abuse treatment, they must conceal their sex offender identities and histories—not a promising foundation for fostering the self-disclosure treatment requires.

The subpopulation of sex offenders among offenders who require interventions for substance abuse issues raises many questions and complications, especially since they also may be concurrently mentally ill, culturally diverse, developmentally disabled, or otherwise high need (Raymond et al. 1999). Sex offenders often stir strong emotions and reactions (Jenkins 1998). The criminal justice system, other offenders, and the community at large typically think of sex offenders, particularly those whose victims are children, as a different class of criminal. Within jails and prisons, if identified, they are at great risk of being victimized by other inmates (and sometimes correctional staff) because of the nature of their crimes. Some States provide sex-offender-specific treatment services for a portion of these inmates, pre- and post-release, and many counties require treatment as one of the conditions of probation (Burton and Smith-Darden 2001). When released from incarceration, sex offenders are required to register with local authorities, often receive more stringent supervision than other offenders, can be subject to community

notification procedures, frequently encounter serious problems finding appropriate housing, and may have their identities and pictures made available on the Internet (Center for Sex Offender Management 2000a).

Some Relevant Facts About Sex Offenders

The image of the typical sex offender conjured by lurid newspaper headlines bears only some resemblance to the actual picture. The blanket term “sex offenders” includes a population so heterogeneous that only a few generalizations are not inaccurate and misleading (Center for Sex Offender Management 2000b). Although once there were thought to be discrete offender types—rapists, child molesters, incest offenders, exhibitionists—an increasing body of evidence derived from polygraph examinations of convicted offenders demonstrates that there is considerable “crossover” between behaviors once thought to define these subgroups. Thus nearly 9 of 10 offenders originally thought to have only adult victims were found, under polygraph examination, also to have victims under 18. Similarly, 36 percent of those convicted of an incest offense disclosed that they also had victimized adults (English et al. 2000). One important distinction, however, is that sexual offenses committed while intoxicated (e.g., date rape) are unusual occurrences and do not represent habitual behavior. These problems are more about impulse control amplified by alcohol and other substance use and often can be treated in substance abuse programs.

It now is generally accepted that no single causative factor can adequately explain the commission of sexual offenses. Only multifactorial explanations that take into account the presence, to various degrees, of deviant sexual arousal, lack of victim empathy, inadequate social skills, personal trauma history, criminal association, thinking errors, and other elements now appear to provide adequate models for understanding these crimes.

The use of alcohol and drugs is seen as contributing to disinhibition but is never thought to be a stand-alone explanation for sexual offending (Laws et al. 2000).

Sex-Offender-Specific Treatment

The emergence, over the past 20 years, of an increasingly solid body of research-based information about sexual offending has led to correspondingly sophisticated treatment models and outcome studies (Marshall et al. 1998). Treatment focus areas are based on an emerging set of “dynamic” (i.e., modifiable) risk variables. One widely used instrument for assessing such factors is the Sex Offender Needs Assessment Rating (SONAR) (Hanson and Harris 2001). Risk factors identified in the SONAR include intimacy deficits, negative social influences, antisocial attitudes, inadequate sexual self-regulation, and general self-regulation. Addressing such factors in non-sex-offender-specific treatment might have some impact on reducing the risk of sexual recidivism. A growing body of solid research provides evidence that, overall, treatment now reduces the reoffense rate between 10 and 17 percent (Center for Sex Offender Management 2001b).

Relapse Prevention: The Common Thread

With some modifications, relapse prevention concepts and formulations borrowed from the substance abuse treatment field have been found to fit sex offender programming needs quite well (Laws 1989; Laws et al. 2000). At present, relapse prevention—or the more broadly designated cognitive-behavioral therapy—has grown to be the dominant model used by most sex offender treatment programs, whether institutional or community-based, so that currently over 80 percent of programs in North America identify “cognitive-behavioral/relapse prevention” as their primary treatment model (Burton and Smith-

SHARPER FUTURE

Awareness of the presence of significant numbers of sex offenders among inmates participating in California's in-prison substance abuse treatment programs—as high as 30 percent—led to the development of a specialized aftercare program specifically tailored to address both substance abuse and sex offense issues concurrently. For many reasons, in-prison programs do not address sex offense issues. SHARPER FUTURE (Social Habilitation and Relapse Prevention – Expert Resources), a private-sector forensic mental health agency, has been operating a program under contract in central Los Angeles since 1999 to meet the needs of parolees who have completed one of the in-prison substance abuse programs but who are screened out of other aftercare programs because of their sex offense histories. (SHARPER FUTURE also has a component to treat offenders with mental disorders.)

SHARPER FUTURE is staffed by licensed clinicians with expertise in treating both areas concurrently. The existence of many parallels between treatment strategies for substance abuse and for sex offense issues offers a foundation for such an integrated approach. Concepts from relapse prevention apply equally well to both areas of concern.

Because of restrictions in California codes prohibiting registered sex offenders from sharing a common residence, SHARPER FUTURE is exclusively outpatient. As an outpatient program, SHARPER FUTURE cannot fully continue but does support the therapeutic community philosophy that is the foundation of the prison-based system. Although the program is considered “aftercare” for substance abuse issues, which have been directly addressed previously in the institutional setting, the sex offense issues are addressed directly for the first time only in this outpatient phase. During the 14-month intensive treatment phase of SHARPER FUTURE, participants, all on parole, attend three 2-hour groups per week. A weekly aftercare group can subsequently continue until the end of the parole period or beyond.

Because personal issues related to substance abuse already have been addressed in prison and because the level of shame related to sex offense behavior generally is much more intense, greater resistance in dealing with the sexual behavior is common. Frequently analogies with substance abuse cycles, behavior chains, thinking errors, low capacity for delayed gratification, and similar themes offer a more acceptable entrance to the sex offense work. Creating a group treatment culture supportive of the work needed to address deviant sexual patterns is essential to treatment success.

Standards of the Association for the Treatment of Sexual Abusers (ATSA—see <http://www.ATSA.com>) require substantial training and experience for staff involved in treating sex offenders and finding such qualified staff, especially individuals who also have expertise in substance abuse treatment, has been a challenge, as has working collaboratively within such a large and complex system as the California Department of Corrections. Future goals include replicating this pilot program in other geographical areas and, ultimately, developing structures to allow the sex offense issues to be addressed from the beginning of treatment in specialized separate tracks of the in-prison substance abuse treatment system.

Darden 2001). Sharing such a common lineage has the benefit of permitting easy movement in the treatment setting between relapse prevention as applied to substance abuse and relapse prevention as applied to sex offending.

Areas of Divergence

Important differences prevent a simplistic merger of sex offender treatment and substance abuse treatment models. Sex offender treatment usually is provided by specially trained—sometimes specifically credentialed—mental health professionals, and interventions can include medical and behavioral efforts to modify deviant sexual arousal patterns (ATSA 2001). Stakes are higher because any “relapse” involves another traumatized victim and can lead to a long, even lifetime, prison sentence. Since the primary goal is community safety, sex offender treatment usually involves close collaboration with the criminal justice system, represented by probation and parole officers. Great caution is exercised with regard to encouraging mutual support efforts between sex offenders and, consequently, self-help support systems are ordinarily unavailable. Treatment themes seldom are discussed freely with support persons outside of the program since the stigma and other social consequences of being a sex offender are considerably higher than for those in substance abuse recovery.

Conclusions and Recommendations

The consensus panel believes the following points and recommendations merit emphasis:

- The panel recommends that screening and assessment for a history of physical/sexual abuse be included as part of intake assessments for men and women in criminal justice treatment settings. Referral information should be provided to inmates who report prior abuse and who are interested in receiving services related to this abuse.
- Use of “strengths-based” approaches to substance abuse treatment is highly recommended, particularly for female offenders. These interventions are considered effective in improving self-esteem.
- Substance abuse treatment programs in jails and prisons (including TCs) should include vocational programs for men and women. Offenders under community supervision also should have access to community vocational programs.
- Treatment programs in women’s institutions are encouraged to use the segregation of genders within the criminal justice system to the advantage of their clients by developing treatment programs that specifically address women’s needs.
- The panel encourages jail and prison programs to allow for more interaction between incarcerated mothers and their children; the 2–4 hours of supervised visitation per week that many institutions allow is not sufficient for mothers or their children.
- Given the high rates of co-occurring mental disorders in the offender population, more treatment programs need to be developed for offenders with COD.
- Given the prevalence of cognitive and physical disabilities in incarcerated populations, especially among offenders with substance use disorders, treatment providers need to be able to screen for and to provide accommodations for offenders who have these co-existing disabilities.
- Because mental health and substance use disorders can mask or imitate each other, accurate diagnosis of these disorders requires skilled screening and assessment. Assessment should look for evidence of both disorders, rather than providing separate assessments for the disorders. Regular reassessment for COD also is important, and should be conducted at major transition points in the criminal justice system by staff with specialized training in this area.
- Substance abuse treatment programs for offenders should include staff who reflect

the cultural diversity of the population they are treating. Efforts need to be made to adopt treatment to specific cultural populations (e.g., ethnicity, race, age, sexual orientation, rural cultures, socioeconomic class, and language). Counselors need to be aware of different cultural sets of values, biases, and assumptions related to communication, therapeutic style, and interper-

sonal contact and should be trained in techniques for adapting treatment approaches to reflect these differences, in order to more effectively engage and maintain clients in program services.

- The therapeutic community has been successfully modified to treat specific populations, including female offenders and offenders with COD.