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Therapeutic Communities in United States' Prisons: Effectiveness and Challenges

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ABSTRACT: The therapeutic community (TC) has become widely accepted and utilised throughout the US criminal justice system and is considered the treatment of choice for the more difficult to treat prison inmates (Prendergast & Wexler, 2004). The acceptance and proliferation of TCs in prisons, which are highly coercive environments and have been historically resistant to rehabilitation, is an intriguing story that may provide useful lessons for other countries interested in providing effective prison treatment for substance abusers. Research has played a central role through federally-funded rigorous evaluations of multiple prison TCs that have consistently demonstrated significant reduction in recidivism, for some studies up to five years post-prison TC treatment followed by aftercare. This report provides a brief history of correctional TCs, including a review of research findings with a focus on several classic studies, a discussion of enhancing correctional TCs in the current environment that increasingly requires 'evidence-based' treatment. Finally, lessons learned and recommendations will be offered for future research and practice

Historical overview[1]

As of year-end 2007, about 7.3 million Americans were under criminal justice supervision (jail or prison, probation or parole); 2.3 million of these were incarcerated in jail or prison (Glaze & Bonczar, 2009; West & Sabol, 2008). The Bureau of Justice Statistics (Mumola & Karberg, 2006) report that, in 2004, 83.2% of inmates in state prisons reported having ever used an illicit drug and 69.2% reported regular use (at least once a week for at least a month). Over half (53.4%) reported experiencing symptoms in the 12 months prior to incarceration that are consistent with a diagnosis of abuse or dependence. Over four-fifths (84%) of inmates diagnosed with abuse or dependence had a prior offense and 53% reported three or more sentences. Moreover, almost half (48%) of state

[1] The historical review relies extensively on an earlier article, Prendergast & Wexler (2004).

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prisoners with an abuse or dependence diagnosis were on some form of criminal justice status (probation, parole, or escape) at the time of their arrest.

Despite the prevalence of drug use, persons incarcerated in state prisons and jails are unlikely to receive adequate substance abuse treatment. Although it is estimated that about 70% of persons in state prisons need treatment, the National Criminal Justice Treatment Practices Survey, conducted as part of the National Institute on Drug Abuse's (NIDA) Criminal Justice Drug Abuse Treatment Studies cooperative, found in a nationwide survey of prisons that the most common substance abuse service provided is drug education (by 74.1% of prisons). The second most common service was group counselling of less than four hours per week (54.6%). Of the prison surveyed, 19.5% provided therapeutic community (TC) treatment in a facility segregated from the general population, and 9.2% in a non-segregated facility (Taxman, Perdoni & Harrison, 2007).

Approximately 600,000 state and federal inmates are released to the community each year (Committee on Law and Justice, 2007). Research to date suggests that most of these inmates will again commit crimes; about 67% will be re-arrested within three years (Langan & Levin, 2002). The low number of substance abuse treatment programmes in prison is believed to contribute to this high rate of recidivism.

'Nothing Works'

The field of prison substance abuse treatment was largely defined by the slogan 'nothing works' with the publication of Lipton, Martinson and Wilks' review of prison treatment literature (Lipton, Martinson & Wilks, 1975). Martinson's famous 'Nothing Works' article in *Public Interest* (1974), followed by his widely-viewed appearance on the 60 Minutes TV show, struck a chord with the public and many policy makers. These events coincided with the exceedingly violent prison riots in the New York State maximum-security prison in Attica. Those riots shocked the public, and drew together liberals and conservatives in a common mistrust of the criminal justice system. Liberals and conservatives agreed that judges and parole officials were not to be trusted with making decisions on sentence length and release to the community (Cullen & Gilbert, 1982). The widespread enactment of determinant sentences was the policy response that contributed to a loss of judicial discretion and longer prison terms. Finally, the drug epidemic of the late 1960s and throughout the 1970s led to tougher drug laws, which together with determinant sentencing led to the extraordinary rise in prison population throughout the 1990s.

Antecedents of 'Prison Substance Abuse Treatment Works'

Several forces combined to move prison-based substance abuse treatment forward. An important influence was the proactive role of the judiciary itself that found that a number of state departments of correction were places of cruel and unusual punishment needing reform under the supervision of court appointed 'Masters'. The drug epidemic anxiety along with 'tough-on-crime' policies and prison overcrowding contributed to a political landscape that set

the stage for receptivity to prison drug treatment programmes. The early positive treatment outcomes of the Cornerstone TC programme in Oregon (Field, 1985) and the Stay 'n Out TC substance abuse treatment programme in New York (Wexler, Falkin, & Lipton, 1990) stimulated considerable interest and some optimism among correctional administrators and policy makers.

Expansion of prison substance abuse treatment

In the late 1980s, two technology transfer initiatives at the federal and state levels began to address the problem of the severe demands on the criminal justice system caused by the increasing numbers of adjudicated substance-abusing offenders. Two major technical assistance efforts, Project REFORM, funded by the Bureau of Justice Assistance, and later Project RECOVERY, funded by the Center for Substance Abuse Treatment (CSAT), provided assistance to 20 states in planning implementation programmes for prisoners with substance abuse problems (Wexler, 1997). The National Drug Control Strategy, prepared annually by the Office of National Drug Control Policy (2009), has consistently recommended the development of prison treatment and rehabilitation services. The Residential Substance Abuse Treatment for State Prisoners Formula Grant Program (RSAT), funded by the US Department of Justice since 1994, authorised multi-year funding to states to develop residential drug treatment in isolated units utilising the TC model for substance-abusing offenders. Over the years, most state prison systems established residential prison substance abuse programmes, and in 2001 RSAT funds became available for re-entry services. However, the percentage of inmates receiving treatment remains low and needs to be expanded.

Over time, increasing attention has been focused on the importance of continuing care in the community following prison-based treatment (often called aftercare). Aftercare's contribution to increasing and maintaining reduced recidivism has been reported by studies conducted in Delaware (Inciardi, Martin, Butzin, Hooper & Harrison, 1997; Martin, Butzin, Saum & Inciardi, 1999), Texas (Knight, Simpson, Chatham & Camacho, 1997; Knight, Simpson & Hiller, 1999), California (Wexler, Melnick, Lowe & Peters, 1999), and among federal inmates (Pelissier, Gaes, Camp, Wallace, O'Neil & Saylor, 1998). These studies consolidated the realisation that effective substance abuse treatment during and following incarceration could be an important strategy to ensure public safety.

The prison TC model

Research played a central role in the development of the prison TC model by providing information that influenced policy makers to support prison substance abuse treatment for the purposes of improving public safety and public health. Beginning in the 1970s, with the development of the Cornerstone and Stay 'n Out programmes, and continuing into the 1990s, the community TC model was modified and adapted to correctional environments, where it became the primary

approach for treating substance abuse among inmates (Wexler, 1986, 1994; Wexler, Blackmore & Lipton, 1991; Wexler & Lipton, 1993; for other, usually short-lived, TCs or TC-like programmes developed in the 1970s, see Lipton, 1998). The rationale for TC-based treatment in prisons is that most inmates have long histories of drug use and dependence requiring high-intensity treatment designed to restructure attitudes and thinking. Unlike shorter, less intensive treatment programmes, the TC model is based on the belief that drug abuse is primarily a symptom of a disordered personality (De Leon, 2000). The therapeutic goal of the TC is a global change in lifestyle involving abstinence from illicit substances, elimination of antisocial activities, and development of employment skills and prosocial attitudes and values. To facilitate these global changes, the therapeutic process includes all of the activities and interactions between the individual and the peer community (Bell, 1994; De Leon, 1995, 1996, 2000; De Leon & Rosenthal, 1989; De Leon & Ziegenfuss, 1986; Kooyman, 1993; Sugarman, 1986; Wexler & Williams, 1986). Increasingly, prison TC programmes are designed to be followed by community aftercare in order to reinforce and consolidate the gains that the parolee made during participation in the prison programme (Inciardi, 1996). Surveys of the membership of the Therapeutic Communities of America (TCA) (Melnick & De Leon, 1999) and the residential TC programmes in the Drug Abuse Treatment Outcome Survey (DATOS; Melnick, De Leon, Hiller & Knight, 2000) show high levels of agreement among TCs as to the nature of the essential treatment elements of TCs, including the treatment approach, the role of the community itself as a therapeutic agent, the use of educational and work activities, and the TC process.

Of all the treatment models, TCs are the most complex to implement and operate in a prison, and require the highest level of commitment from the prison administration and staff. While residents must take responsibility for their own recovery process, treatment staff, including ex-offenders, act as role models and provide support and guidance. Individual counselling, encounter groups, peer pressure, role models, and a system of incentives and sanctions form the core of treatment interventions in a TC. Residents of the community live together, participate together in groups, and study together. In the process, inmates learn to manage their behaviour, to become more honest with themselves and others, to develop self-reliance, and to accept responsibility for their actions.

Prison TC research

Since the 1980s, six major evaluations of prison-based TC treatment have been published, as well as several smaller studies. The main programme evaluations have been those conducted at Cornerstone in Oregon (Field, 1985, 1989), Stay 'n Out in New York (Wexler et al., 1990), KEY/CREST in Delaware (Inciardi et al., 1997; Inciardi, Martin & Butzin, 2004; Lockwood & Inciardi, 1993; Martin et al., 1999), New Vision in Texas (Knight et al., 1997; Knight et al., 1999), Amity in California (Wexler et al., 1999; Wexler, De Leon, Thomas, Kressler, & Peters, 1999; Prendergast et al., 2004) and the Federal Bureau of Prison programmes

(Pelissier et al., 1998; Pelissier et al., 2000; Pelissier, Camp & Motivans, 2003). Positive results have generally been found at 12, 24, 36, and 60 months, but differences between the treatment and comparison groups tend to converge at 36 months except for the groups that have aftercare. Overall, the findings have been taken as supportive of the effectiveness of providing treatment in prison, particularly when combined with community treatment following release to parole (for recent reviews of the literature on prison-based treatment, see MacKenzie, 2002 and Prendergast & Wexler, 2004).

Data from the Stay 'n Out, KEY/CREST, and Amity evaluations provide a sense of the outcomes that have impacted policy and secured the role of TCs in US corrections.

The Stay 'n Out study was the first major prison TC recidivism outcome study funded by NIDA. Inmates were randomly assigned to the TC or control groups, and several other convenience samples were analysed, including an adult Milieu group and a young adult (18–21) Counselling group (see Figure 1). Among the most important findings was that the percentage of TC males rearrested (27%) was significantly lower than for the no-treatment control (41%) and for the two comparison treatment groups (35% for the milieu group, 40% for the counselling group). Similarly, the percentage of TC females re-arrested (18%) was significantly lower than the no-treatment control group (24%) and counselling group (30%). The research also found a strong relationship between time in programme and treatment outcomes, with an optimum treatment duration of 9–12 months. For male inmates who participated in Stay 'n Out, the percentage of those who had no parole infractions during community supervision rose from 50% for those who remained less than three months to almost 80% for parolees who were in the programme between nine and twelve months. Similar findings were obtained for the females, although the percentages of those discharged positively from parole were higher than for their male counterparts (79% for females in treatment less than three months, 92% for the 9-to-12-month group). Based upon the Stay 'n Out results, most correctional TCs in the US have been placed in isolated prison units and with durations of 9–12 months.

A second major evaluation of the use of the TC with substance-abusing inmates was that of the KEY/CREST programme in Delaware (Martin et al., 1999). This study tested the effects of enhancing prison TC treatment (KEY) with transitional treatment under community supervision at a community-based work-release programme for men and women (the CREST Outreach Center), followed by further community-based TC participation (see Figure 2). The researchers examined three groups of CREST participants: CREST dropouts (n=109), CREST completers not receiving community TC treatment (n=101), and CREST+TC completers receiving TC community treatment (n=69). Although overall effects declined from earlier follow-up periods (Inciardi et al., 1997), 69% of the CREST+TC group had not been arrested in the three years since their release, whereas only 28% of CREST dropouts and 55% of CREST completers had not been arrested. Likewise, while 35% of the CREST+TC group remained drug-free at three years' post-release, only 17% of dropouts and 27% of completers were drug-free. A five years' post-release assessment (Inciardi et al., 2004)

showed similar results, with treatment completers who entered tertiary aftercare being less likely to recidivate or resume drug use compared with the no-treatment group, and slightly more likely when compared to completers who did not enter tertiary aftercare.

Figure 1: Arrest outcomes from the Stay 'n Out evaluation

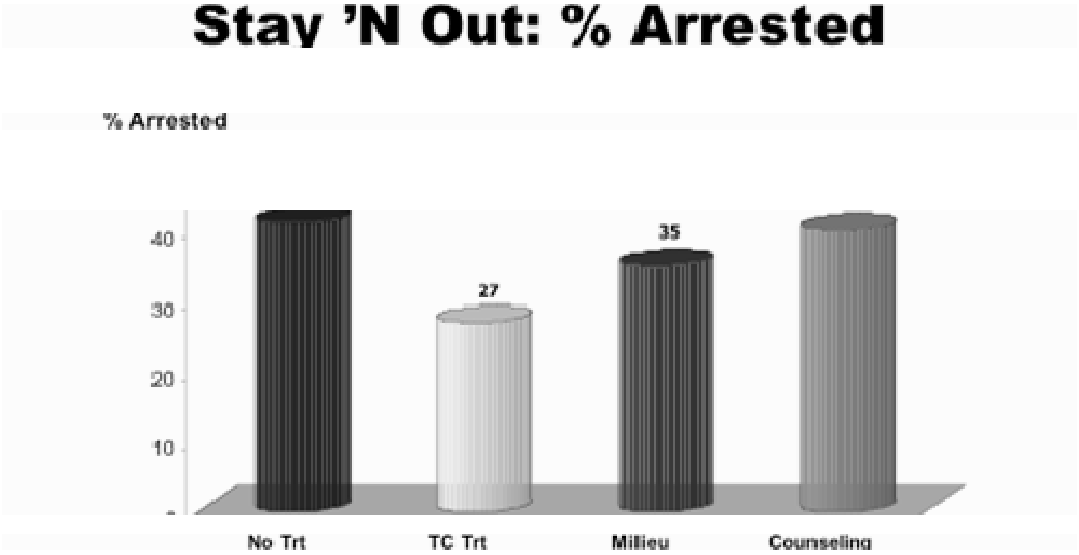
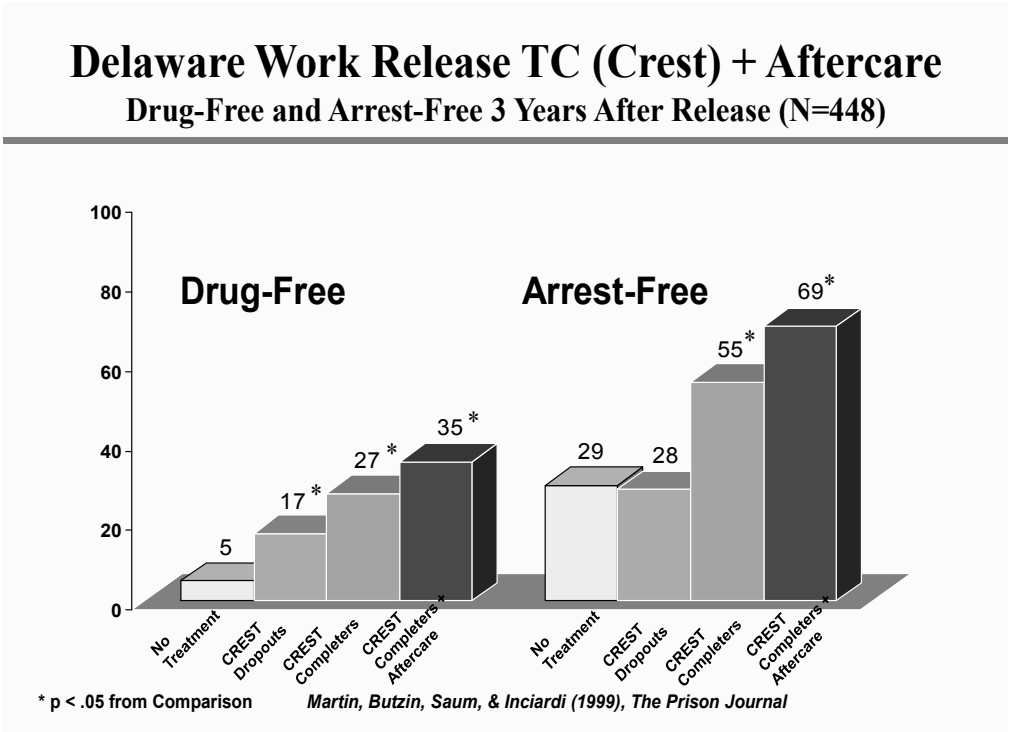


Figure 2: Drug and arrest outcomes from the Crest evaluation



The Amity study was especially important because it was one of the first systematic evaluations of a prison TC followed by aftercare. The study utilised an intent-to-treat design with random assignment and with a one-year follow-up. There were two NIDA-funded follow-up studies at one year (Wexler et al., 1999) and five years (Prendergast et al., 2004) post-prison, shown in Figures 2 and 3. At one year the experimental group had a 16% significantly lower recidivism rate. Based on that significant difference, the experimental group was divided into prison TC dropouts and completers and aftercare dropouts (left programme within 30 days or less) and completers, with the only significant and very large difference found for the aftercare completers who had a very small (8%) recidivism rate. These first findings were highly influential in gaining acceptance for the TC in California prisons.

Figure 3: Return-to-custody outcomes from the Amity evaluation at one year

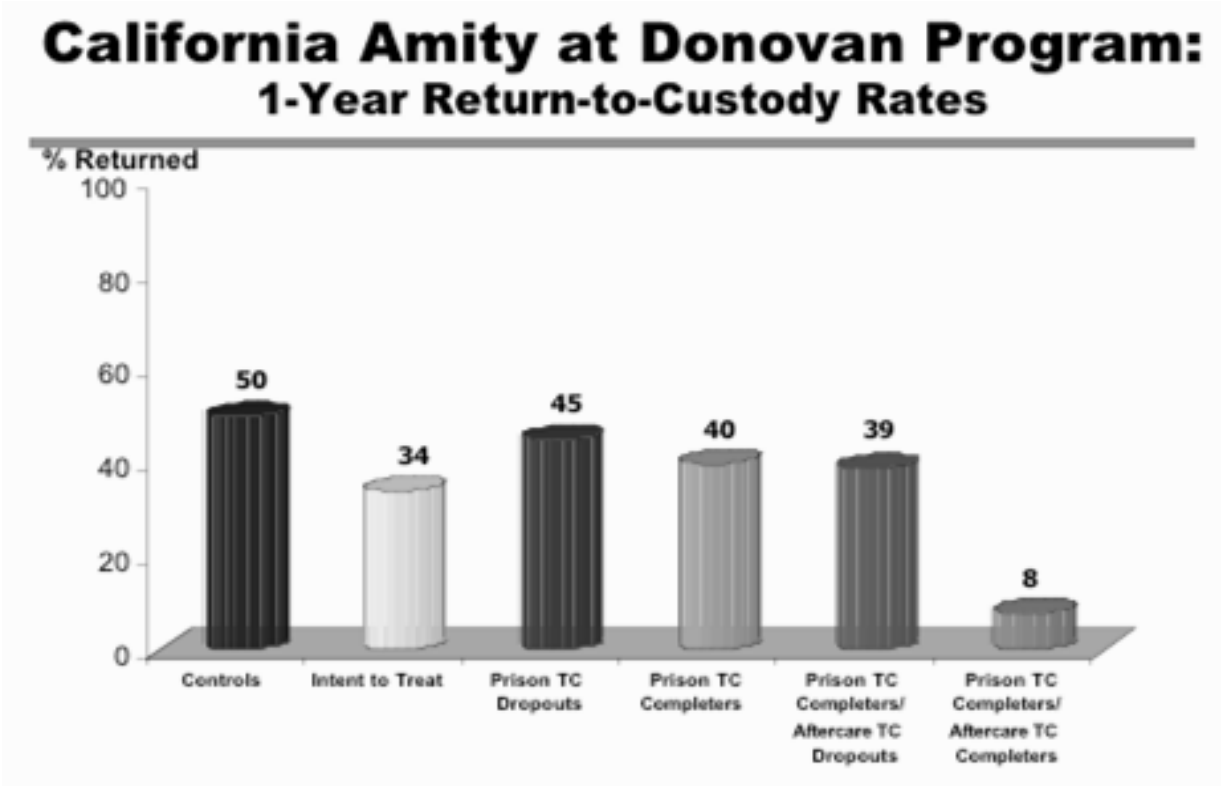
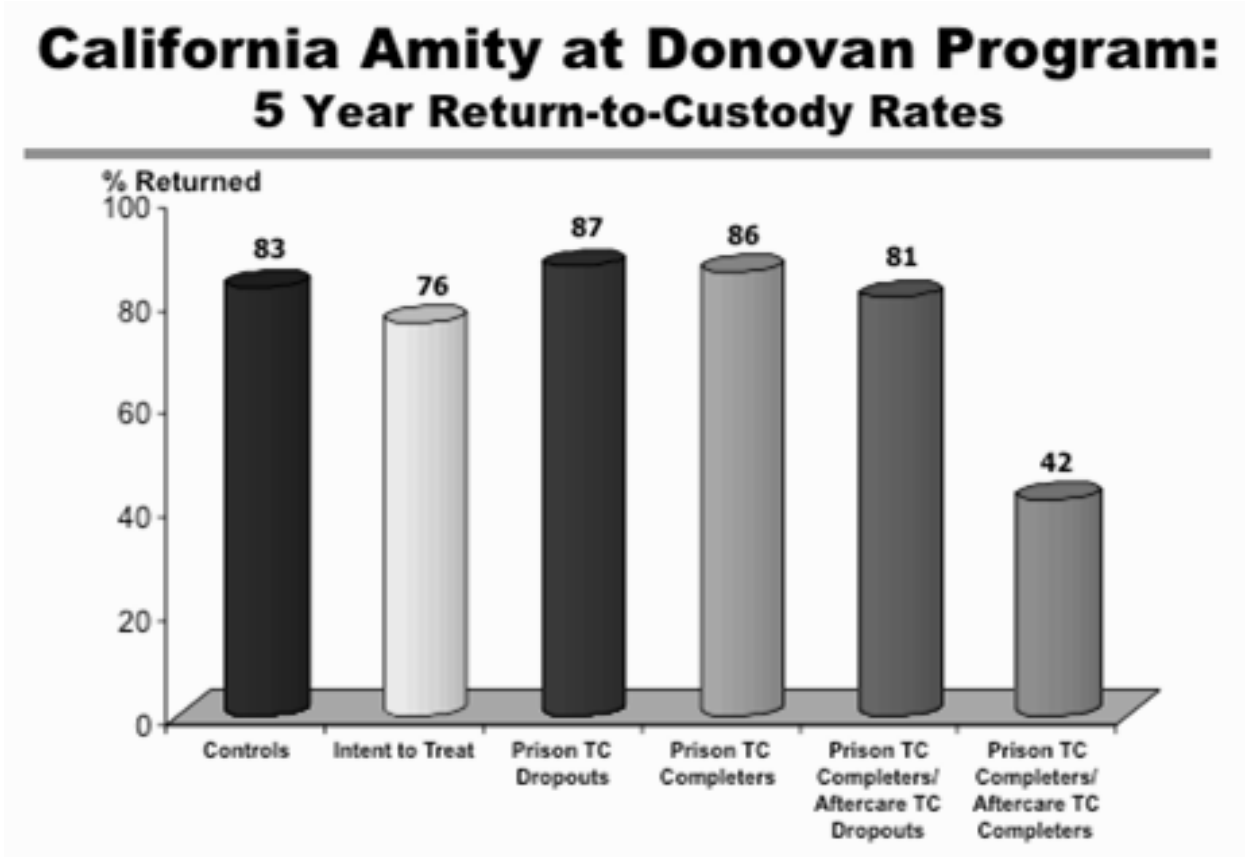


Figure 4 shows the same pattern of findings for the five-year outcomes, but all the groups have greater levels of recidivism over the additional time-at-risk. The 7% experimental/control difference was significant, and again the major finding was the very low aftercare recidivism rate of 42% for the aftercare completers, which was significantly lower than that of the other groups. The groups also differed significantly in employment during the year prior to follow-up, with employment being reported by 72% of the aftercare completers, 40% of the prison TC dropouts, and 56% of the prison TC completers.

Figure 4: Return-to-custody rates in the Amity evaluation at five years



The Amity studies were highly influential in California and, largely based on the Amity findings, until recently the California Department of Corrections and Rehabilitation (CDCR) has had a network of over 12,000 treatment slots in 44 prison TCs located in 21 prisons and an extensive aftercare network (California Department of Corrections and Rehabilitation, 2009).[2]

The research on aftercare has been robust and replicated but limited. As Prendergast and Wexler (2004) note, the research on aftercare to date contains several critical methodological limitations: (1) lack of unbiased assignment to aftercare conditions; (2) confounding of the separate effects of treatment duration and aftercare and their interactions; and (3) lack of a TC aftercare condition for parolees who do not have prior in-prison TC treatment. Research is needed to remedy the identified weaknesses of earlier studies by random assignment to TC and non-TC aftercare; by rigorously investigating the separate and combined effects of differential treatment duration and aftercare; and by providing TC and other types of aftercare to inmates who did not receive in-prison treatment. The following questions should guide the next generation of research regarding aftercare: Is aftercare alone capable of significantly reducing recidivism and relapse to drug use following prison? What is the effect of shorter-term prison treatment (i.e. less than six months) with and without

[2] Due to a severe budget crisis in California, the TC treatment capability has been radically reduced but remains operational.

aftercare?[3] What is the optimum combination of duration of in-prison and aftercare treatment? What treatment models are best suited to deal with the inherent geographic dispersion of offenders after their release from prison? What are the costs and cost–benefits of prison treatment and aftercare?

Acceptance and challenges of correctional TCs[4]

As discussed above, research has played a very important role in the acceptance of correctional substance abuse treatment. However, if TCs were unacceptable to correction systems the research would have been little more than of academic interest. Prisons are designed to remove adjudicated offenders from the public and to maintain them in secure custodial environments, and interventions that interfere with this primary mission are not allowed in prison. Within prisons, inmate identities are essentially reduced to numbers, and custodial regulations tightly control most aspects of their behaviour and are generally repressive of creativity and individuality. In addition, prison inmates in the general population are typically careful not to share personal feelings and open up about intimate and often painful life experiences. Thus, it is somewhat curious that TCs, fundamentally dedicated to rehabilitation that includes personal exploration, self-disclosure and individual growth, have been widely accepted in US prisons. Some of the reasons are presented below.

Primacy of public safety

The acceptance of treatment by the criminal justice system has required that treatment providers have acknowledged the primacy of safety and security within the prison setting. Criminal justice supervisory and monitoring requirements take precedence and must be adhered to for clinicians to have client access. Once an individual enters the criminal justice system, substance abuse and mental health considerations recede and become important secondary issues. ‘Prisons are not hospitals’ is an important reminder for clinicians who want to maximise their effectiveness and ability to work safely and cooperatively with correctional personnel.

Personal accountability and compatibility of substance abuse treatment and correctional practices

TCs are largely based on self-help notions of acceptance of responsibility for substance abuse and related antisocial behaviour, and rely on group and individual counselling (along with peer influence) to achieve the goals of harm reduction and long-term abstinence. Substance abuse treatment providers and

[3] California budget reductions have forced CDCR to reduce in-prison TCs’ duration from 9–12 months to 3 months and to decrease aftercare availability, creating conditions to test some of these questions.

[4] These arguments have been presented previously (Wexler, 2003).

criminal justice professionals generally agree on the antisocial nature of substance abuse and the need for appropriate consequences. They also agree on the need for inmates to take responsibility for their behaviour and to work hard on learning pro-social behaviours needed for sobriety and recidivism reduction. Based on a number of shared values, over the years, resolution of differences between the systems has usually been successfully achieved. For example, offering inmates roles of authority in programmes based on their progress is problematic. Inmates are not usually allowed to directly supervise other inmates, although this is common in the hierarchical community-based TC model. Prison TC operators have responded to this difference in orientations by having advanced residents serve as role models and teachers who guide and inform instead of supervise.

Treatment benefits for prison administration

The acceptance and expansion of prison treatment was facilitated as prison administrators realised their operational benefits. Well-run prison treatment programmes help stabilise prison units and create more humane environments for inmates, as well as for treatment and custody staff. This is especially true for self-help-oriented TCs that require high levels of respectful behaviour for staff and peers (Wexler & Williams, 1986). Observers of prison treatment programmes have noted that programme units are the preferred job choices for custody staff, who often request to be assigned to programmes. There have been reports of few negative behavioural incidents on programme units and of reports of low levels of stress and fewer sick days among correctional officers (Deitch, Koutsenok & Ruiz, 2004; Prendergast, Farabee & Cartier, 2001).

System-wide TC implementation challenges

Researchers who have studied prison-based TCs (Farabee, Prendergast, Cartier, Knight, Wexler & Anglin, 1999), as well as correctional officials (Cate, 2007), have identified a number of problems that can limit their effectiveness. These include: 1) prison procedures such as ‘lock downs’ that interfere with hours of programme operation; 2) hours of programming often limited to four hours per day, with no programming on weekends, making it difficult to maintain a TC environment; 3) mandating assignment to treatment without balancing incentives for participation; 4) use of limited or inappropriate criteria to determine eligibility for TC admissions; 5) difficulty in hiring and keeping trained staff for low paying positions; 6) frequent turnover in correctional staff undermines support for and continuity in programming; 7) ongoing struggles to maintain treatment beds in the face of overcrowding; and 8) competition between contractors for securing contracts decreases the beneficial sharing of information. Any large prison system interested in developing networks of prison TCs will need to consider these and other challenges and develop ongoing system improvement approaches.

Future direction for Prison TCs

The success of the TC model in prisons has led to its application to special populations including women (Sacks et al., 2008), inmates with co-occurring disorders (Sacks, Banks, McKendrick & Sacks, 2008), and inmates in maximum security prisons (Wexler, Burdon & Prendergast, 2005). There have been discussions regarding developing prison TCs to address the needs of youthful and elderly inmates.

TC research paradigm considerations

Is the TC an evidence-based practice?

The term 'evidence-based practice' has become a buzzword in health services' research and particularly in discussions of substance abuse treatment. United States' federal and state agencies that fund substance abuse treatment programmes in the community and criminal justice system now regularly require that applicants include evidence-based treatments from specified lists.[5] Although there is considerable controversy about the meaning of 'evidence-based', more rigorous definitions specify a minimum of three components: 1) results must be based on studies that utilise clinical trials methodology (random assignment and intent to treat analyses; 2) replication across studies by different research teams; and 3) availability of a manual for disseminating and replicating the protocol (e.g. Blueprints for Violence Prevention). As reported above, the TC has clearly passed the first two hurdles; however, there is not a single universally accepted manual for either community or prison TCs. While there have been many efforts to develop TC standards including the prison TC (American Correctional Association, 2005), the closest document to a manual is an excellent book by De Leon (2000) that is affectionately known in the field as the 'Red Book'. Although De Leon provides an excellent description of TC theory, structure, and processes, it is a 400-page document and not a manual suitable for dissemination of an evidence-based protocol. Currently, there are efforts underway with the World Federation of Therapeutic Communities (WFTC) to create an internationally accepted basic manual that describes essential TC elements, and guides the process of programme implementation (Wexler, personal communication, 2009).[6]

Appropriate TC research methodology?

Consideration of appropriate TC research methodologies raises the question of defining and clarifying the TC phenomenon in terms of science, medicine, social services and education. Each realm has different research methodologies, and

[5] The Substance Abuse & Mental Health Services Administration (SAMHSA) maintains a web site 'A Guide to Evidence-Based Practices (EBP) on The Web', http://www.samhsa.gov/ebpwebguide/index.asp with links to generally accepted EBP lists.

[6] Currently, the first author is in conversations with the WFTC to create an approved TC manual.

requirements for membership and funding. For example, to obtain treatment reimbursement or federal funds for programme development and evaluation, the TC must present itself as essentially a medical treatment for substance abuse.

The applicability of experimental research methodology for evaluating the TC has been debated in the field over the years. Some have argued that the TC model is a teaching community (e.g. 'community as method', De Leon, 2000) rather than a specific protocol designed for the treatment of a single dysfunction;[7] as a result, clinical trials research methodology may not be the best way to empirically study the modality (De Leon, Inciardi & Martin, 1995). Few would question the value of schools that provide education and skills development for students, so perhaps the more important issue may be how to best develop and deliver an effective curriculum within the TC learning community. For example, instead of experimentally comparing the TC to a cognitive behavioural intervention, an alternative approach might be to use the TC to house and compare different symptom-targeted approaches like Relapse Prevention Therapy (Marlatt, Parks & Witkiewitz, 2002) and Individual Cognitive-Behavioural Therapy (Carroll, 1998) that appear on the University of Washington's list of 'Evidence-Based Practices for Substance Use Disorders'.

Exploring the notion of the TC as a general treatment structure that can house a variety of discrete interventions moves us away from the medical model of specific treatment protocols for defined dysfunctions toward a model of socialisation and education. These considerations are reminiscent of the TC roots as a self-help phenomenon operated by people who were not adequately served by traditional medically oriented treatment and who formed communities to help themselves (e.g. Jones, 1954). At this juncture, it may be time to study the TC as a community using more modern approaches such as the emerging science of social networks (Christakis & Fowler, 2009) that studies behavioural influences through the connections between people, membership groups, and extended groups over time. The study of social networks offers opportunities to explore basic rehabilitation questions of how persons move from criminal cultures through treatment communities (e.g. TCs) into non-criminal cultures.

Conclusions and recommendations

Interest in implementing prison TCs has been growing around the world, creating a need for guiding information in addition to the demonstration of successful outcomes.[8] Based on 35 years of experience in the US, a number of lessons have emerged that lead to recommendations.

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[7] De Leon (2000) offers the TC perspective that drug abuse is a disorder of the whole person who has problems with socialisation and cognitive and emotional development.

[8] An indication of international interest is that the senior author was invited to present historical overviews of US prison TCs at three international conferences in 2009.

First and most important, programme operators need to realise that prisons are not hospitals or treatment programmes but they are custody environments where safety and security is of the utmost importance. Once programme designers accept that they are 'guests' operating in another's 'house', the process of communication and negotiating programme space is considerably advanced. Based on the early prison TC research (Wexler, Falkin, Lipton & Rosenblum, 1992), there is general acceptance that a TC needs to be placed in an isolated unit, be of 9–12 months duration, and work with inmates immediately prior to release. To accomplish these demanding conditions (prisons are often overcrowded, so space is of a premium), there needs to be strong support from correctional leadership ranging from the head of the corrections department to the warden and on down the chain of command. Unless the message of acceptance and support is very clear, programmes can be sabotaged at every level; for example, getting through security gates and 'strip searches' can be exceedingly time consuming and deleterious to programme staff morale. An important guiding notion is to form partnerships between programme and custodial staff at all levels and maintain a steady flow of information to avoid misunderstandings and perceived threats to security.

An excellent procedure that fosters partnering and support used in many US prisons that host programmes is 'cross training' where programme and custodial staff train each other. Prison personnel train all programme staff in security procedures and the TC staff often use an immersion method to orient correction officers to the TC. A TC immersion training may last for 3–5 days where participants are placed in a mock TC and participate in TC activities (e.g. morning meetings, encounter groups, seminars, etc.) to get an experiential sense of the modality. The TC trainings often help create lasting bonds and a sense of respect and trust between the two groups of staff members.

It is especially useful for prison systems to identify recruit providers with successful community TCs with a proven track record and if possible prior prison experience. The advantages of a community TC contractor include a working knowledge of TC procedures, the availability of recovering staff, and community treatment beds that are a critical component of successful prison TC treatment. Based on informal surveys of the authors over many years and in many states, TC programmes run by outside experienced contractors are generally superior to those operated by the correctional system. The employment of recovering staff needs to be emphasised because they contribute to the integrity and credibility of the programme. Using his or her own life as an example of what is possible for an inmate with a substance abuse history, the recovering staff member provides credible role modelling that is highly impactful.

Another recommendation is to establish relationships with researchers who can help evaluate how programmes are actually operating and whether they are effective in achieving their goals. One suggestion is to engage a researcher or research team that has a track record of successful grant writing and

completion of evaluation projects, and is committed to dissemination through conferences and published articles.[9] A corollary is to engage research assistance to capture programme processes through observation and qualitative interviews and client progress through validated clinical assessment instruments administered at admission, during treatment, and upon completion and, when possible, collection of post-treatment outcome data. The ability to produce empirical data about programme function, population treatment, and outcomes is extremely useful for ongoing funding in these days of evidence-based treatment.

Prison TC research would benefit if staff and programme participants were to be part of the research process through orientations and ongoing presentation of findings. Maximising staff and client engagement in the research process would help to improve the quality of studies and to interpret findings prior to public dissemination. During the early Amity research when researchers were spending time in the programme-collecting baseline and process data, a series of meetings with staff and residents where preliminary data were presented elicited many questions and comments that helped clarify what the numbers meant and enriched interpretations.

Finally, the Internet has become a most useful tool for all research endeavours, and two organisations that provide especially helpful research and programme improvement online resources are The Institute of Behavioral Research at Texas Christian University and NIATx. The TCU research group offers a number of client and programme assessment instruments for prison and community programmes, and NIATx offers information and strategies for programme improvement.

Currently the recession has caused major budgetary problems across the US, halting the expansion of prison drug treatment and leading to the closure of many prison programmes and reduction of aftercare services in many states. Severe budgetary shortfalls have led to the deconstruction of respected state-wide prison TC systems most evident in California. The closing of well-developed programmes and reduction of a skilled TC workforce will take considerable dedication and significant time to rebuild. As the recession passes, it is reasonable to expect that expansion of prison drug treatment based on the TC model will resume based on the large body of research and its general acceptance as an evidence-based practice. An important effort to concentrate on during these difficult years will be the development of an international accepted prison TC manual that will guide the rebuilding efforts as economies revive worldwide in the future.

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[9] When the Amity programme was starting in 1990, programme founders Rod Mullen and Naya Arbiter contacted the first author based on his experience of evaluating the Stay'n Out prison TC in New York and asked him to develop a NIDA grant to evaluate the new Amity prison programme in California.

References

American Correctional Association (2005). *Performance based standards for therapeutic communities*. Alexandria, VA: ACA.

Bell, D.C. (1994). Connection in therapeutic communities. *International Journal of the Addictions, 29*, 525–543.

Blueprints for Violence Prevention, http://www.colorado.edu/cspv/blueprints/criteria.html

California Department of Corrections and Rehabilitation (CDCR) (2009). *Annual report: Division of Addiction and Recovery Services*. Sacramento: CDCR.

Carroll, K.M. (1998). *A cognitive-behavioral approach: Treating cocaine addiction* (NIDA Therapy Manual for Drug Addiction, no. 1). Bethesda, MD: National Institute on Drug Abuse.

Cate, M.L. (2007). *Special review into in-prison substance abuse programs managed by the California Department of Corrections and Rehabilitation*. Sacramento: Office of the Inspector General.

Christakis, N.A. and Fowler, J.H. (2009). *Connected: The surprising power of our social networks and how they shape our lives.* New York: Little Brown and Company.

Committee on Law and Justice (2007). *Parole, desistance from crime, and community integration*. Washington, DC: National Academy Press.

Cullen, F. and Gilbert, K. (1982). *Reaffirming rehabilitation*. Cincinnati: Anderson Publishing Co.

Deitch, D.A., Koutsenok, I. and Ruiz, A. (2004). In-custody therapeutic community substance abuse treatment: Does it have an impact on custody personnel? *Criminal Justice Policy Review*, *15*(1), 61–83.

De Leon G. (1995). Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions*, *30*, 1603–1645.

De Leon, G. (1996). Therapeutic communities: AIDS/HIV risk and harm reduction. *Journal of Substance Abuse Treatment*, *13*(5), 411–420.

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

De Leon, G., Inciardi, J.A. and Martin, S.S. (1995). Residential drug abuse treatment research: Are conventional control designs appropriate for assessing treatment effectiveness? *Journal of Psychoactive Drugs*, *27*(1), 85–91.

De Leon, G. and Rosenthal, M.S. (1989). Treatment in residential communities. In T.B. Karasu (Ed.), *Treatment of psychiatric disorders*, Vol. II. Washington, DC: American Psychiatric Press.

De Leon, G. and Ziegenfuss, L.J. (Eds.) (1986). *Therapeutic communities for addictions: Readings in theory, research, and practice*. Springfield, IL: Charles C. Thomas Publishing.

Farabee, D., Prendergast, M., Cartier, J., Knight, K., Wexler, H. and Anglin, M. (1999). Barriers to the implementation of prison-based substance abuse treatment programs. *Prison Journal*, *79*(2), 150–162.

Field, G. (1985). The Cornerstone program: A client outcome study. *Federal Probation*, *49*, 50–55.

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

Glaze, L.E. and Bonczar, T.P. (2009). *Probation and probation in the United States, 2007: Statistical tables* (NCJ 224707). Washington, DC: Bureau of Justice Statistics, US Department of Justice.

Inciardi, J.A. (1996). The therapeutic community: An effective model for corrections-based drug abuse treatment. *Drug treatment behind bars: Prison-based strategies for change* (pp. 65–74). Westport, CT: Praeger Publishers/Greenwood Publishing Group, Inc.

Inciardi, J., Martin, S. and Butzin, C. (2004). Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison. *Crime & Delinquency*, *50*(1), 88–107.

Inciardi, J.A., Martin, S.S., Butzin, C.A., Hooper, R.M. and Harrison, L.D. (1997). An effective model of prison-based treatment for drug-involved offenders. *Journal of Drug Issues*, *27*(2), 261–278.

Jones, M. (1954). *The therapeutic community*. New York: Basic Books.

Knight, K., Simpson, D.D., Chatham, L.R. and Camacho, L.M. (1997). An assessment of prison-based drug treatment: Texas' in-prison therapeutic community program. *Journal of Offender Rehabilitation*, *24*(3/4), 75–100.

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

Kooyman, M.A. (1993). *The therapeutic community for addicts: Intimacy, parent involvement and treatment outcome.* Amsterdam, The Netherlands: Swets and Zeitlinger.

Langan, P.A. and Levin, D.J. (2002). *Recidivism of prisoners released in 1994*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

Lipton, D.S. (1998). Therapeutic community treatment programming in corrections. *Psychology, Crime, and Law*, *4*, 213–263.

Lipton, D.S., Martinson, R. and Wilks, J. (1975). *The effectiveness of correctional treatment*. New York: Praeger Publishers.

Lockwood, D. and Inciardi, J.A. (1993). CREST Outreach Center: A work release iteration of the TC model. In J.A. Inciardi, F.M. Tims and B.W. Fletcher (Eds.), *Innovative approaches in the treatment of drug abuse: Program models and strategies* (pp. 61–69). Westport, CT: Greenwood Press/Greenwood Publishing Group, Inc.

MacKenzie, D.L. (2002). Reducing the criminal activities of known offenders and delinquents: Crime prevention in the courts and corrections. In L.W. Sherman, D.P. Farrington, B.C. Welsh and D.L. MacKenzie (Eds.), *Evidence based crime prevention* (pp. 330–404). London: Routledge.

Marlatt, G.A., Parks, G.A. and Witkiewitz, K. (2002). *Clinical guidelines for implementing relapse prevention therapy.* Illinois: The Behavioral Health

Recovery Management Project. Accessed electronically on 08/25/04 at: http://www.bhrm.org/guidelines/RPT%20guideline.pdf

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

Martinson, R. (1974). What works? Questions and answers about prison reform. *Public Interest*, *35*, 22–54.

Melnick, G. and De Leon, G. (1999). Clarifying the nature of therapeutic community treatment: First validity study of the Survey of Essential Elements Questionnaire (SEEQ). *Journal of Substance Abuse Treatment*, *16*(4), 307–313.

Melnick, G., De Leon, G., Hiller, M. and Knight, K. (2000). Therapeutic communities: Diversity in treatment elements. *Substance Use and Misuse*, *35*(12–14), 12–14.

Mumola, C.J. (1999). *Substance abuse and treatment, state and federal prisoners*. Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

Mumola, C.J. and Karberg, J.C. (2006). *Drug use and dependence, State and Federal prisoners, 2004* (Bureau of Justice Statistics Special Report, NCJ Publication No. 213530). Washington, DC: Department of Justice.

NIATx, https://www.niatx.net/Home/

Office of National Drug Control Policy (2009). *National Drug Control Strategy: 2009 Annual Report*. Washington, DC: Office of the President.

Pelissier, B., Camp, S.D. and Motivans, M. (2003). Staying in treatment: How much difference is there from prison to prison? *Psychology of Addictive Behaviors*, *17*(2), 134–141.

Pelissier, B., Gaes, G.G., Camp, S.C., Wallace, S.B., O'Neil, J.A. and Saylor, W.G. (1998). *TRIAD drug treatment evaluation project: Six-month interim report.* Washington, DC: Office of Research and Evaluation, Federal Bureau of Prisons.

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

Prendergast, M., Farabee, D. and Cartier, J. (2001). The impact of in-prison therapeutic community programs on prison management. *Journal of Offender Rehabilitation*, *32*(3), 63–78.

Prendergast, M., Hall, E., Wexler, H., Melnick, G. and Cao, Y. (2004). Amity prison-based therapeutic community: Five-year outcomes. *Prison Journal, 84*(1), 36–60.

Prendergast, M. and Wexler, H.K. (2004). Correctional substance abuse treatment programs in California: A historical perspective. *Prison Journal*, *84*(1), 8–35.

Sacks, S., Banks, S., McKendrick, K. and Sacks, J. (2008). Modified therapeutic community for co-occurring disorders: A summary of four studies. *Journal of Substance Abuse Treatment*, *34*(1), 112–122.

Sacks, J.Y., Sacks, S., McKendrick, K., Banks, S., Schoeneberger, M., Hamilton, Z., Stommel, J. and Shoemaker, J. (2008). Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use and HIV risk). *Journal of Offender Rehabilitation*, *46*(3–4), 233–261.

Sugarman, B. (1986). Structure, variations, and context: A sociological view of the therapeutic community. In G. De Leon and J.T. Ziengenfuss (Eds.), *Therapeutic communities for addictions: Readings in theory, research, and practice* (pp. 65–83). Springfield, IL: Charles C. Thomas.

Taxman, F.S., Perdoni, M.L. and Harrison, L.D. (2007). Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment*, *32*(3), 239–254.

The Institute of Behavioral Research at Texas Christian University, http://www.ibr.tcu.edu/

University of Washington. *Evidence-Based Practices for Substance Use Disorders*, http://adai.washington.edu/ebp/

West, H.C. and Sabol, W.J. (2008). *Prisoners in 2007* (NCJ 224280). Washington, DC: Bureau of Justice Statistics, US Department of Justice.

Wexler, H.K. (1986). Therapeutic communities within prisons. In G. De Leon and J.T. Ziegenfuss (Eds.), *Therapeutic communities for addictions: Readings in theory, research and practice* (pp. 227–237). Springfield, IL: Charles C. Thomas, Publishers.

Wexler, H.K. (1994). Progress in prison substance abuse treatment: A five-year report. *Journal of Drug Issues*, *24*(2), 361–372.

Wexler, H.K. (1997). Therapeutic communities in American prisons. In E. Cullen, L. Jones and R. Woodard (Eds.), *Therapeutic communities in prisons.* John Wiley & Sons Ltd.

Wexler, H.K. (2003). The promise of prison-based treatment for dually diagnosed inmates. *Journal of Substance Abuse Treatment*, *25*, 223–231.

Wexler, H.K., Blackmore, J. and Lipton, D.S. (1991). Project REFORM: Developing a drug abuse treatment strategy for corrections. *Journal of Drug Issues*, *21*(2), 473–495.

Wexler, H., Burdon, W. and Prendergast, M. (2005). Maximum security prison therapeutic community and aftercare: First outcomes. *Offender Substance Abuse Report, 5*(6), 81–82, 91–94.

Wexler, H.K., De Leon, G., Thomas, G., Kressler, D. and Peters, J. (1999). The Amity prison TC evaluation: Reincarceration outcomes. *Criminal Justice and Behavior*, *26*(2), 147–167.

Wexler, H.K., Falkin, G.P. and Lipton, D.S. (1990). Outcome evaluation of a prison therapeutic community for substance abuse treatment. *Criminal Justice and Behavior*, *17*(1), 71–92.

Wexler, H.K., Falkin, G.P., Lipton, D.S. and Rosenblum, A.B. (1992). Outcome evaluation of a prison therapeutic community for substance abuse treatment. In C.G. Leukefeld and F.M. Tims (Eds.), *Drug abuse treatment in prisons and jails* (NIDA Research Monograph 118, pp. 156–175). Rockville, MD: National Institute on Drug Abuse.

Wexler, H.K. and Lipton, D.S. (1993). From REFORM to RECOVERY: Advances in prison drug treatment. In J. Inciardi (Ed.), *Drug treatment and criminal justice*. Newbury Park: Sage Publications.

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

Wexler, H.K. and Williams, R. (1986). The Stay 'n Out therapeutic community: Prison treatment for substance abusers. *Journal of Psychoactive Drugs*, *18*(3), 221–230.

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