The Therapeutic Community

A Model Program for the Treatment of Drug-Involved Offenders

James A. Inciardi, Hilary L. Surratt, and Steven S. Martin[2]

Abstract

With growing numbers of drug-involved offenders coming to the attention of the criminal justice system, substance abuse treatment has become a critical part of the overall correctional process. The therapeutic community appears to be a treatment modality especially well suited for correctional clients because its intensive nature addresses their long-term treatment needs. A multistage therapeutic community treatment system has been implemented in the Delaware correctional system, and the components of a prison-based therapeutic community as well as specific therapeutic activities are described at length. The centerpiece of the treatment process occurs during work release – the transitional stage between prison and the free community. When evaluating this program, 690 individuals in four research groups were followed: treatment graduates with and without aftercare, treatment dropouts, and a "no treatment" comparison group. At 5 years after release, treatment graduates, with or without aftercare, had significantly greater probabilities of remaining both arrest-free and drug-free than did those without treatment. Treatment dropouts were slightly, though not significantly, less likely to be arrested on a new charge as those without treatment, but were significantly more likely to be drug free. These outcome data suggest that the widespread implementation of such treatment programs would bring about significant reductions in both drug use and drug-related crime.

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The relationship between drug use and criminal activity has been well documented. For example, follow-up studies of career addicts in Baltimore have found high rates of criminality among heroin users during those periods they are addicted and markedly lower rates during times of non-addiction (Ball et al., 1981; Ball, Shaffer, & Nurco, 1983; Nurco et al., 1985). Street studies conducted in Miami, Florida have demonstrated that the amount of crime drug users commit is considerable, that drug-related crime is at times quite violent, and that the criminality of street drug users is far beyond the control of law enforcement (Inciardi, 1989; Inciardi, Horowitz, & Pottieger, 1993; Inciardi & Pottieger, 1998). Research conducted elsewhere, furthermore, has arrived at similar conclusions (Anglin & Hser, 1987; Goldstein et al., 1989; Johnson et al., 1985). And what the majority of the research seems to be saying is that although the use of cocaine, heroin, and other drugs does not necessarily initiate criminal careers, it does tend to intensify and perpetuate them. That is, street drugs tend to freeze users into patterns of criminality that are more acute, dynamic, unremitting, and enduring than those of other offenders.

A concomitant of drug-related criminality and the U.S. "war on drugs" has been increased numbers of drug-involved offenders coming to the attention of the criminal justice system. Furthermore, it has been reported that perhaps two-thirds of those entering state and federal penitentiaries have histories of substance abuse (see Leukefeld, Tims, & Farabee, 2002; Leukefeld & Tims, 1992). As such, there has been considerable interest in recent years in both providing and improving drug abuse treatment programs in correctional settings.

However, much has been written about the problems of implementing new drug treatment programs in penitentiary settings because despite any arguments to the contrary, the primary task of prisons is custody. The internal order of the prison is maintained by strictly controlling the inmates and regimenting every aspect of their lives. In addition to their loss of freedom and basic liberties, goods and services, heterosexual relationships, and autonomy, they are deprived of their personal identities. Upon entering prison, inmates are stripped of their clothing and most of their personal possessions; and they are examined, inspected, weighed, documented, classified, and given a number. Thus, prison becomes painful, both physically and psychologically (Clemmer, 1958; Sykes, 1965).

The pains of imprisonment and the rigors and frustrations of confinement leave but a few paths open to inmates. They can bind themselves to their fellow captives in ties of mutual aid and loyalty, in opposition to prison officials. They can wage a war against all, seeking their own advantage without reference to the needs and claims of others. Or they can simply withdraw into themselves. Ideally these alternatives exist only in an abstract sense, and most inmates combine characteristics of the first two extremes. Within this balance of extremes an inmate social system emerges and functions, and one of the fundamental elements of this social system is the prison subculture.

Every correctional facility has its subculture, and every prison subculture has its system of norms that influence prisoners' behaviour, typically to a far greater extent than the institution's formally prescribed rules. These subcultural norms are informal and unwritten rules, but their violation can evoke sanctions from fellow inmates ranging from simple

ostracism to physical violence and death. Many of the rules revolve around relations among inmates and interactions with prison staff, while others reflect preoccupations with being "smart," "tough," and street wise. As such, this prison code often tends to militate against reform in general, and drug rehabilitation in particular, or as one Delaware inmate put it, "people in treatment are faggots" (Inciardi, Lockwood, & Martin, 1991).

In addition, there are many other phenomena in the prison environment that make rehabilitation difficult. Not surprisingly, the availability of drugs in prisons is a pervasive problem. Moreover, in addition to the one-on-one violence that seems to be a concomitant of prison life, there is the violence associated with inmate gangs, often formed along race/ethnic lines for the purposes of establishing and maintaining status, "turf," and unofficial control over certain sectors of the penitentiary. Within this setting, it would appear that if any drug rehabilitation approach had a chance of succeeding, it would be the therapeutic community.

The Therapeutic Community

The therapeutic community (or "TC" as it is most commonly called) is a total treatment environment isolated from the rest of the street or prison population -- separated from the drugs, the violence, and the norms and values that rebuff attempts at rehabilitation. The primary clinical staff of the TC are typically former substance abusers -- "recovering addicts" -- who themselves were rehabilitated in therapeutic communities. The treatment perspective of the TC is that drug abuse is a disorder of the whole person -- that the problem is the *person* and not the drug, that addiction is a *symptom* and not the essence of the disorder. In the TC's view of recovery, the primary goal is to change the negative patterns of behaviour, thinking, and feeling that predispose drug use. As such, the overall goal is a responsible drug-free lifestyle (see De Leon & Ziegenfuss, 1986; Yablonsky, 1989).

Recovery through the TC process depends on positive and negative pressures to change, and this is brought about through a self-help process in which relationships of mutual responsibility to every resident in the program are built. Or as the noted TC researcher Dr. George De Leon once described it:

The essential dynamic in the TC is mutual self-help. Thus, the day-to-day activities are conducted by the residents themselves. In their jobs, groups, meetings, recreation, personal, and social time, it is residents who continually transmit to each other the main messages and expectations of the community (De Leon, 1985). In addition to individual and group counseling, the TC process has a system of explicit rewards that reinforce the value of earned achievement. As such, privileges are *earned.* In addition, TCs have their own specific rules and regulations that guide the behaviour of residents and the management of their facilities. Their purposes are to maintain the safety and health of the community and to train and teach residents through the use of discipline. TC rules and regulations are numerous, the most conspicuous of which are total prohibitions against violence, theft, and drug use. Violation of these cardinal rules typically results in immediate expulsion from a TC.

The essential elements of modern therapeutic communities consist of a series of concepts, beliefs, assumptions, program components, and clinical and educational practices that are apparent to a greater or lesser degree in every TC. A cataloguing and description of these elements was accomplished by TC researcher George De Leon with the help of a national panel of TC experts (De Leon, 1997; Melnick & De Leon, 1993). As De Leon has explained, at the core of the TC approach is what might be termed *community as method* (De Leon, 1997). The primary concepts that characterize "community as method" include:

- *Use of Participant Roles:* Individuals contribute directly to all activities of daily life in the TC, which provides learning opportunities through engaging in a variety of roles.
- *Use of Membership Feedback:* The primary source of instruction and support for individual change is the peer membership.
- *Use of Membership as Role Models:* Each participant strives to be a role model of the change process. Along with their responsibility to provide feedback to others as to what they must change, members must also provide examples of how they can change.
- *Use of Collective Formats for Guiding Individual Change:* The individual engages in the process of change primarily with peers. Education, training, and therapeutic activities occur in groups, meetings, seminars, job functions, and recreation.
- *Use of Shared Norms and Values:* Rules, regulations, and social norms protect the physical and psychological safety of the community. However, there are beliefs and values that serve as explicit guidelines for self-help recovery and teaching right living.
- *Use of Structure and Systems:* The organization of work (e.g. the varied job functions, chores, and management roles) needed to maintain the daily operations of the facility, is a main vehicle for teaching self-development.
- *Use of Open Communication:* The public nature of shared experiences in the community is used for therapeutic purposes.
- *Use of Relationships*: Friendships with particular individuals, peers, and staff are essential to encourage the individual to engage and remain in the change process.
- *Use of Language:* TC argot is the special vocabulary used by residents to reflect elements of its subculture, particularly its recovery and right living teachings. As with any special language, TC argot represents individual integration into the peer community. However, it also mirrors the individuals' clinical progress.

Beyond these, for a program to be a generic TC program model, it must include the following 14 essential elements (De Leon, 1997):

- *Community Separateness:* TC-oriented programs have their own names, often innovated by the clients, and are housed in a space or locale that is separated from other agency or institutional programs and units or generally from the drug-related environment.
- *A Community Environment:* The inner environment contains communal space to promote a sense of commonality and collective activities (e.g., groups, meetings). The walls display signs that state in simple terms the philosophy of the program, the messages of right living and recovery.

- *Community Activities:* To be effectively utilized, treatment or educational services must be provided within a context of the peer community. Thus, with the exception of individual counselling, all activities are programmed in collective formats.
- *Peers as Community Members:* Members who demonstrate the expected behaviors and reflect the values and teachings of the community are viewed as role models.
- *Staff as Community Members:* The staff are a mix of recovered professionals and other traditional professionals (e.g., medical, legal, mental health, and educational) who must be integrated through cross-training that is grounded in the basic concepts of the TC perspective and community approach.
- *A Structured Day*: Regardless of its length, the day has a formal schedule of varied therapeutic educational activities with prescribed formats, fixed times, and routine procedures. The structure of the program relates to the TC perspective, particularly the view of the client and recovery.
- *Phase Format:* The treatment protocol, or plan of therapeutic and educational activities, is organized into phases that reflect a developmental view of the change process. Emphasis is on incremental learning at each phase, which moves the individual to the next stage of recovery.
- *Work as Therapy and Education:* Consistent with the TC's self-help approach, all clients are responsible for the daily management of the facility (e.g., cleaning activities, meal preparation and service, maintenance, purchasing, security, coordinating schedules, preparatory chores of groups, meetings, seminar activities).
- *TC Concepts:* There is an organized curriculum focused on teaching the TC perspective, particularly its self-help recovery concepts and view of right living.
- *Peer Encounter Groups:* The peer encounter is the main community or therapeutic group, although other forms of therapeutic, educational, and support groups are utilized as needed. The minimal objective of the peer encounter is to heighten individual awareness of specific attitudes or behavioural patterns that should be modified.
- *Awareness Training:* All therapeutic and educational interventions involve raising the individuals' consciousness of the impact of their conduct and attitudes on themselves and the social environment, and conversely the impact of the behaviors and attitudes of others on themselves and the social environment.
- *Emotional Growth Training:* Achieving the goals of personal growth and socialization involves teaching individuals how to identify feelings, express feelings appropriately, and manage feelings constructively through the interpersonal and social demands of communal life.
- *Planned Duration of Treatment:* How long individuals must be program-involved depends on their stage of recovery, although a minimum period of intensive involvement is required to ensure internalization of the TC teachings.
- *Continuance of Recovery:* Completion of primary treatment is a stage in the recovery process. Thus, whether implemented within the boundaries of the main program or separately as in special halfway houses, the perspective and approach guiding aftercare programming must be continuous with that of primary treatment in the TC.

The Staging of Corrections-Based TC Treatment

Based on experiences with correctional systems and populations, with corrections-based drug treatment, and with the evaluation of a whole variety of correctional programs, it would appear that the most appropriate strategy for effective TC intervention with inmates would involve a three-stage process (Inciardi, Lockwood, & Martin, 1991). Each stage in this regimen of treatment would correspond to the inmate's changing correctional status -- incarceration, work release, and parole (or whatever other form of community-based correction operates in a given jurisdiction).

The *primary stage* should consist of a prison-based therapeutic community designed to facilitate personal growth through the modification of deviant lifestyles and behaviour patterns. Segregated from the rest of the penitentiary, recovery from drug abuse and the development of pro-social values in the prison TC would involve essentially the same mechanisms seen in community-based TCs. Therapy in this primary stage should be an on-going and evolving process. Ideally, it should endure for 9 to 12 months, with the potential for the resident to remain longer, if necessary. As such, recruits for the TC should be within 18 months of their work release date at the time of treatment entry.

It is important that TC treatment for inmates begin *while they are still in the institution,* for a number of reasons. In a prison situation, time is one of the few resources that most inmates have an abundance of. The competing demands of family, work, and the neighbourhood peer group are absent. Thus, there is the *time* and opportunity for comprehensive treatment -- perhaps for the first time in a drug offender's career. In addition, there are other new opportunities presented -- to interact with "recovering addict" role models; to acquire pro-social values and a positive work ethic; and to initiate a process of education, training, and understanding of the addiction cycle.

Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration whereby inmates are permitted to work for pay in the free community but must spend their nonworking hours either in the institution, or more commonly, in a community-based work release facility or "halfway house." Inmates qualified for work release are those approaching their parole eligibility or conditional release dates. Although graduated release of this sort carries the potential for *easing* an inmate's process of community reintegration, there is a negative side, especially for those whose drug involvement served as the key to the penitentiary gate in the first place.

This initial freedom exposes many inmates to groups and behaviors that can easily lead them back to substance abuse, criminal activities, and reincarceration. Even those receiving intensive therapeutic community treatment while in the institution face the prospect of their recovery breaking down. Work release environments in most jurisdictions do little to stem the process of relapse. Since work release populations mirror the institutional populations from which they came, there are still the negative values of the prison culture. In addition, street drugs and street norms tend to abound.

Graduates of prison-based TCs are at a special disadvantage in a traditional work release centre since they must live and interact in what is typically an anti-social, non-productive setting. Without clinical management and proper supervision, their recovery can be severely threatened. Thus, secondary TC treatment is warranted. This *secondary stage* is a "transitional TC" -- the therapeutic community work release centre.

The program composition of the work release TC should be similar to that of the traditional TC. There should be the "family setting" removed from as many of the external negative influences of the street and inmate cultures as is possible; and there should be the hierarchical system of ranks and job functions, the rules and regulations of the environment, and the complex of therapeutic techniques designed to continue the process of resocialization. However, the clinical regimen in the work release TC must be modified to address the correctional mandate of "work release."

In the *tertiary stage,* clients will have completed work release and will be living in the free community under the supervision of parole or some other surveillance program. Treatment intervention in this stage should involve out-patient counselling and group therapy. Clients should be encouraged to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, to call on their counsellors on a regular basis, and to participate in monthly one-to-one and/or family sessions. They should also be required to spend one day each month at the program, and a weekend retreat every three months.

The TC Continuum in the Delaware Correctional System

This three stage model has been made operational within the Delaware correctional system, and is built around three therapeutic communities -- The KEY, The KEY Village, and CREST Outreach Center.

"The KEY" is a prison-based therapeutic community for male inmates located at the Multi-Purpose Criminal Justice Facility in Wilmington, Delaware. The KEY represents the primary stage of TC treatment, and was established in 1988 as a 40-bed program through a United States Department of Justice planning grant. In 1990, the State of Delaware took over the funding of the program, expanding it from its original 40 beds to 70. In June of 1993, the State began allocating funds for further expansions of the program to over 300 beds at several locations.

In general terms, the treatment regimen at The KEY follows a holistic approach. Different types of therapy -- behavioural, cognitive, and emotional -- are used to address individual treatment needs (Hooper, Lockwood, & Inciardi, 1993). Briefly:

1. *Behavioral Therapy* fosters positive demeanour and conduct by not accepting antisocial actions. To implement this, behavioural expectations are clearly defined as soon as a new resident is admitted to the program. At that time, the staff's primary focus is on how the resident is to behave. The client works with an orientation manual which he is expected to learn thoroughly. Once again, the focus is on his behaviour as opposed to

thoughts and feelings. As the client learns and adjusts to the routines of the therapeutic community, more salient issues are dealt with in the treatment process.

2. *Cognitive Therapy* helps individuals recognize errors and fallacies in their thinking. The object is to help the client understand how and why certain cognitive patterns have been developed across time. With this knowledge the client can develop alternative thinking patterns resulting in more realistic decisions about life. Cognitive Therapy is accomplished in both group and individual sessions.

3. *Emotional Therapy* deals with unresolved conflicts associated with interactions with others and the resulting feelings and behaviors. To facilitate this treatment strategy, a non-threatening but nurturing manner is required so that clients can gain a better understanding of how they think and feel about themselves as well as others.

A number of techniques are employed to implement these three alternative therapeutic approaches and to motivate individuals to change, including transactional analysis, psychodrama, and branch groups. *Transactional analysis* involves a detailed assessment of the roles that one plays in interactions with others. The ego states affecting behaviour are defined in terms of "parent," "adult," and "child." Through group and individual sessions, clients are taught how to recognize which ego state they typically select for certain interactions and the effects of allowing their behaviour to be controlled by that ego state.

In the *psychodrama,* individuals relive and explore unresolved personal feelings and thoughts. Through this process, clients are helped to bring to closure unresolved issues which have prevented them from developing more adequate life-coping skills. Group and individual sessions are used as the vehicle for this treatment.

In *branch groups,* clients meet on a routine basis to share both feelings and thoughts about the past and present. In-depth thoughts and feelings are dealt with so that there can be a better understanding of how a person is perceiving his world. With this understanding, he is in a better position to develop more adequate coping skills.

"The KEY Village" is a prison-based therapeutic community for women inmates located at the Baylor Women's Correctional Institution in New Castle, Delaware. Like The KEY, the KEY Village represents the primary stage of TC treatment, and was established in during the closing months of 1993 through a Center for Substance Abuse Treatment grant. The Village follows a treatment regimen similar to that at The KEY, but with adaptations designed specifically for women.

During the closing months of 1990, the Center for Drug and Alcohol Studies at the University of Delaware was awarded a 5-year treatment demonstration grant from the U.S. National Institutes of Health to establish a work release therapeutic community. Known as "CREST Outreach Center," it represented the first work release TC in the United States, and it was designed to incorporate stages 2 and 3 of the treatment process outlined above.

The treatment regimen at CREST Outreach Center follows a 5-phase model over a 6-month period. *Phase One* is composed of entry, assessment and evaluation, and

orientation, and lasts approximately two weeks. New residents are introduced to the house rules and schedules by older residents. Each new resident is also assigned a primary counsellor, who initiates an individual needs assessment. Participation in group therapy is limited during this initial phase, so that new residents can become familiarized with the norms and procedures at CREST.

Phase Two emphasizes involvement in the TC community, including such activities as morning meetings, group therapy, one-on-one interaction, confrontation of other residents who are not motivated toward recovery, and the nurturing of the newer people in the environment. During this phase, residents begin to address their own issues related to drug abuse and criminal activity, in both group sessions and during one-on-one interactions. As well, they begin to take responsibility for their own behaviors by being held accountable for their attitudes and actions in group settings and in informal interactions with residents and staff. Residents are assigned job functions aimed at assuming responsibility and learning acceptable work habits, and they continue to meet with their primary counsellors for individual sessions. However, the primary emphasis in Phase Two is on becoming an active community member through participating in group therapy and fulfilling job responsibilities necessary to facility operations. This phase lasts approximately eight weeks.

Phase Three continues the elements of Phase Two, and stresses role modeling and overseeing the working of the community on a daily basis (with the support and supervision of the clinical staff). During this phase, residents are expected to assume responsibility for themselves and to hold themselves accountable for their attitudes and behaviors. Frequently, residents in this phase will confront themselves in group settings. They assume additional job responsibilities by moving into supervisory positions, thus enabling them to serve as positive role models for newer residents. They continue to have individual counselling sessions, and in group sessions they are expected to help facilitate the group process. Phase Three lasts for approximately 5 weeks.

Phase Four initiates preparation for gainful employment, including mock interviews, seminars on job seeking, making the best appearance when seeing a potential employer, developing relationships with community agencies, and looking for ways to further educational or vocational abilities. This phase focuses on preparing for re-entry to the community and lasts approximately two weeks. Residents continue to participate in group and individual therapy, to be responsible for their jobs in the CREST facility. However, additional seminars and group sessions are introduced to address the issues related to finding and maintaining employment and housing as well as returning to the community environment.

Phase Five involves "re-entry," i.e., becoming gainfully employed in the outside community while continuing to live in the work release facility and serving as a role model for those at earlier stages of treatment. This phase focuses on balancing work and treatment. As such, both becoming employed and maintaining a job are integral aspects of the TC work release program. During this phase, residents continue to participate in house activities, such as seminars and social events. They also take part in group sessions addressing

issues of employment and continuing treatment after leaving CREST. In addition, residents begin to prepare to leave CREST. They open a bank account and begin to budget for housing, food, and utilities. At the end of approximately 7 weeks, which represents a total of 26 weeks at CREST Outreach Center, residents have completed their work release commitment and are free to live and work in the community as program graduates.
The CREST Outreach Center community is comprised of women and men at a variety of stages of treatment. Through this interaction, newer residents are given hope and encouragement for changing their lifestyles and the older residents can assess their own changes and become positive role models. Moreover, beginning in Phase Two, residents are encouraged to engage family and significant others in the treatment process through family and couples groups led by CREST counsellors.

Because the majority of CREST graduates have probation and/or parole stipulations to follow after their period of work release, an *aftercare* component was developed to ensure that graduates fulfil probation/parole requirements. This represents the tertiary phase of treatment, providing continued treatment services so as to decrease the risk of relapse and recidivism. This aftercare program endures for six months, and requires total abstinence from drug and alcohol use, one two-hour group session per week, individual counselling as scheduled, and urine monitoring. Graduates must return once a month to serve as role models for current CREST clients. Participation in a 12-step AA (Alcoholics Anonymous) and/or NA (Narcotics Anonymous) program is also encouraged.

Postscript

The Center for Drug and Alcohol Studies at the University of Delaware was funded by the U.S. National Institute on Drug Abuse to evaluate the relative effectiveness of the prison and work release treatment programs described above. Field follow-ups were conducted on all KEY and CREST clients, as well as on a no-treatment/work release comparison group. A 6-month follow-up occurred at the completion of work release, with subsequent follow-ups at 18, 42 and 60 months after the client has been released from prison. At all of these points, HIV and urine testing occurred, as well as in-depth assessments of drug use and HIV risk behaviors. Currently, 5-year follow-up data on 592 clients, and the outcome data are quite positive. For example,

- Of those clients in the no-treatment/work release comparison group, only 21% were arrest free at the 5-year follow-up;
- Of those who dropped out of treatment, only 29% were arrest free at the 5-year follow-up;
- Of those who completed treatment, but did not participate in the aftercare program, 43% were arrest free at the 5-year follow-up; and,
- Of those who complete both treatment and aftercare, 54% were arrest free at the 5-year follow-up.

Going further, the proportions of offenders who were drug free at the 5-year follow-up was significant when compared to the control group. It must be emphasized here that the “drug free” measure was quite rigorous -- total abstinence from all illicit drugs during the entire

follow-up period, as measured by both self-report and urine testing at each point of contact. As such:

- Of those clients in the no-treatment/work release comparison group, only 3% were drug free at the 5-year follow-up;
- Of those who dropped out of treatment, only 16% were drug free at the 5-year follow-up;
- Of those who completed treatment, but did not participate in the aftercare program, 25%% were arrest free at the 5-year follow-up; and,
- Of those who complete both treatment and aftercare, more than half (26%) were arrest free at the 5-year follow-up.

These data document that the clients who participated in the full continuum of treatment were more likely to be drug-free and arrest free at the end of 5 years than any other group. Interestingly, these data also point to the importance of length of stay in treatment, and that even treatment drop-outs had more positive outcomes than those in the no-treatment group.

Finally, the success of the KEY-CREST was cited in the enabling legislation for the U.S. Dept. of Justice Residential Substance Abuse Treatment Program that greatly increased correctional treatment in the United States in the late 1990s. The Delaware success story has also been discussed in meetings organized by the National Institutes of Health (NIH), the National Institute of Justice, the White House Office of National Drug Control Policy, the U.S. Sentencing Commission, and the U.S. Senate and House of Representatives. NIH has produced and distributed videos on the programs; their successes have been topics of discussion in numerous Congressional hearings; the program was cited by former President Clinton on several occasions; it has been featured on national news programs; and drug treatment programs in Australia, Latin America, Europe, and South Asia were modelled after the Delaware experiment.

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