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Running Title: TREATMENT IN PRISONS AND JAILS

Treatment in Prisons and Jails

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OVERVIEW

In order to understand the context in which correctional substance abuse treatment services are provided, it is important to highlight several key differences between jails and prisons. Prisons are distinct from jails in that they only house inmates who are sentenced for more than one year of incarceration, and who have generally committed serious and/or more frequent offenses in comparison to jail inmates. Inmates confined in jails are either sentenced for a period of less than a year, or are unsentenced and awaiting trial or sentencing. Prison systems are typically much larger than jails, and sometimes feature separate institutions for inmates of differing security levels, or for inmates who need treatment for their mental health or substance abuse problems. Jails are typically operated by municipalities or counties, whereas prisons are operated by state or federal governments. Both jail and prison systems vary widely in the amount and type of resources that are allocated for substance abuse treatment.

Jail and prison populations in the U.S. have increased dramatically during the last several decades, due in large part to the arrest and incarceration of drug offenders. There are currently 1.3 million adult offenders incarcerated in state and federal prisons, and 631,000 adult offenders incarcerated in jails. [(1)] This represents a 415% increase in prison populations and a 340% increase in jail populations since 1980. There are now over a 250,000 drug offenders in state prisons, up from 19,000 in 1980, and approximately 3% of all U.S. citizens are under some type of correctional supervision. [(2)] Several factors have contributed to the growing correctional populations. These include new sentencing laws and policies (e.g., laws establishing mandatory minimum sentences) adopted in the

1980's and 1990's, abolition of parole in many jurisdictions, and law enforcement practices that have focused on street-level drug users and sellers.

The costs associated with expanding jails and prison systems are enormous. The average cost for incarcerating a jail or prison inmate ranges from $20,000-23,000 per year. [3] Approximately $40 billion was spent on U.S. prisons and jails in 2000, including $24 billion to incarcerate non-violent offenders, many of whom are drug offenders. An estimated 77% of correctional costs are linked to substance abuse, representing approximately 10 times the amount that states spend on substance abuse treatment, prevention, and research. [4] In response to the high cost of incarcerating drug offenders, states have begun to revise sentencing statutes to provide early release and reduced sanctions for drug offenders. [5] Ballot initiatives passed in a number of states authorize participation in substance abuse treatment in lieu of incarceration for non-violent drug offenders. Proposition 36 in California was one of the first such initiatives, and allocates $60-120 million per year to fund treatment services, vocational training, family counseling, literacy training, and probation supervision and court monitoring. According to analyses conducted by the California Legislature, Proposition 36 would result in the need for 11,000 fewer prison beds, and would result in an annual savings of $200–250 million. [6]

TREATMENT NEEDS IN JAILS AND PRISONS

With the closing of state mental hospitals, reductions in public treatment services, and the narrowing scope of private insurance coverage, jails and prisons have increasingly served as "public health outposts" and human service providers of "last resort". [7] In recent years, an increasingly greater proportion of jail and prison inmates

are homeless, mentally ill, and have substance use disorders and other chronic health problems . [8] For example, between 6-12% of jail inmates have a severe mental disorder, [9-11] and approximately 10% of jail and prison inmates report mental health problems or a history of residential mental health treatment. [12] Jails and prisons have had to adapt new types of services for the growing numbers of inmates with specialized health care needs, including those with HIV/AIDS and those with co-occurring mental health and substance use disorders. [13] Many offenders have not previously received adequate dental, mental health, substance abuse, or other health care services, and arrive at jails or prisons with preexisting conditions and a range of acute care needs. A significant proportion of these individuals do not have established relationships with community substance abuse or health care programs. [7]

Well over half of jail and prison inmates have significant substance abuse problems, and need treatment services. [14-15] Within jails, two-thirds of adult arrestees in metropolitan jails test positive for drugs, and 70% of inmates are either arrested for a drug offense or report using drugs on a regular basis. [16-17] The lifetime prevalence rates of substance abuse or dependence disorders among prisoners is 74%, including 46% for drug dependence and 37% for alcohol dependence. [18] These rates are markedly higher than in the general population. [19] In recognition of the significant need for substance abuse treatment in jails and prisons and the lengthy amount of time that is often available to provide services in these settings, incarceration is seen by many as an important opportunity to capitalize on periods of emotional crisis and to promote major lifestyle change. [21]

In recent years there has been an emerging gap between the need for substance abuse treatment services in jails and prisons and the scope of services provided . [15, 20-24] Less than 6% of state and federal prison budgets are currently spent on substance abuse treatment, [25] and only 10-12% of prison inmates receive any form of substance abuse treatment. [12,26] The "war on drugs" has not apparently been waged in correctional settings, as the rate of inmate participation in treatment declined from 25% to 10% between 1991 and 1997. [12] A recent national survey of correctional and detention facilities determined that only 56% of state prisons, and 33% of jails provided any type of substance abuse treatment services. [27-28] Only 21% of treatment services in jails, and 31% in state prisons are provided in treatment units that are isolated from the general inmate population. Moreover, many jail and prison treatment programs are not comprehensive in scope, and rely on peer or inmate "counselors" to provide AA and NA groups. Similarly, the staff/inmate ratio is quite low in correctional treatment programs, averaging 1:25 in state prisons. [27-28]

Several national surveys confirm the need for more extensive substance abuse treatment services in jails and prisons. A survey conducted by the American Jail Association [29] found that only 28% of jails reported substance abuse treatment services. Among jails reporting treatment services, only 18% featured paid staff, and only 7% had a comprehensive level of services. Few jails were found to provide transition or reentry services. Surveys conducted by the U.S. Department of Justice in 1997 and 1998 found that 43% of jails and 56% of state prisons reported substance abuse treatment programs. [1,16] Among the jails surveyed, 64% reported self-help programs (e.g., AA/NA) and 30% provided drug education services, and only 12% provided a combination of treatment,

self-help groups, and drug education programs. A striking finding of the survey was that only 4% of jail inmates received any type of treatment services during their current incarceration, and less than 2% received counseling services.

HISTORICAL TRENDS IN CORRECTIONAL TREATMENT SERVICES

Correctional substance abuse treatment services have been influenced by a cyclical pattern of political support for either punishment or rehabilitation of offenders. [30] County and state fiscal problems, including recent revenue shortfalls, have also led to significant reductions in jail and prison substance abuse treatment services. Correctional treatment programs were first offered in the late 1920's, when the U.S. Congress established hospital-based programs for those with opiate addiction, although relatively few programs were developed in jails and prisons before the 1960's. During the 1960's, several states enacted civil commitment statutes that required substance abuse treatment in secure settings. The Narcotic Addict Rehabilitation Act (NARA) passed by Congress in 1966 required in-prison treatment of narcotic addicts who were convicted of federal crimes. The emerging NARA-supported treatment services were essentially residential hospital programs that were situated in prisons.

A number of correctional therapeutic community (TC) programs were implemented in the 1970's, but it wasn't until a decade later that TC programs received widespread support through federal initiatives such as Project REFORM and Project RECOVERY. [31-33] These initiatives led to implementation of TC's in a number of state correctional systems, and supported a variety of training and technical support services. Since this time, the Residential Substance Abuse Treatment (RSAT) formula grant program funded by the U.S. Department of Justice has supported a wide range of

treatment programs in state prisons and in local correctional and detention facilities. Additional prevention and treatment services have been funded through block grants provided by the Department of Justice.

The scope and quality of prison-based treatment services in the U.S. has varied considerably over the last several decades. Until recently, several of the most highly populated states (e.g., California) maintained only a few prison-based substance abuse treatment programs, while several smaller states (e.g., Oregon) have developed an extensive array of in-prison and post-release services. Perhaps the most comprehensive set of treatment services is provided by the Federal Bureau of Prisons. [34] Several other countries such as Canada, Denmark, and Germany have developed a range of substance abuse treatment and harm reduction programs in correctional settings that are broader in scope and application than many of the correctional programs in the U.S. [35-36] In Canada, for example, correctional treatment programs focus not only on substance abuse, but also include cognitive-behavioral interventions, problem-solving, and other psychosocial skills that are relevant to the broader inmate population.

THE CORRECTIONAL TREATMENT ENVIRONMENT

Several unique environmental elements of jails and prisons affect the ability to provide substance abuse treatment services. [20] Jails house a large number of unsentenced inmates for short periods of time, many of whom may be released from incarceration with little advanced warning. These individuals may be reluctant to disclose information that could adversely influence their pending case, and may be less interested in treatment than their judicial disposition. Jail and prison schedules are very regimented, and include large blocks of time when inmates are involved in structured work or educational

activities, or are locked in their cells for "count". Due to the large volume of staff and inmate movement, and to architectural constraints, jails and prisons are often very noisy and lack privacy and dedicated space for treatment activities. In recent years, several treatment-oriented prisons have been built that provide better accommodation for group space, staff offices, and privacy in treatment settings. Work activities in jails and prisons often compete with treatment. For example, in many prisons, inmates may receive early release for employment but not for involvement in substance abuse treatment.

Correctional systems have as their primary focus the control and security of inmates, and have not traditionally provided significant attention to the substance abuse needs of incarcerated offenders. Conflicts often arise within jails and prisons between treatment and security staff, who may have different perspectives regarding the importance of treatment and methods for dealing with inmate infractions, "critical incidents", and contraband. Although basic correctional mental health treatment services are mandated by the courts, there are fewer requirements for substance abuse treatment services. Similarly, while mental health disorders are widely viewed as having biological and medical origins, substance abuse disorders are misunderstood by many as reflecting "moral weakness", and as intractable to treatment. As a result, jail and prisons systems vary widely in the scope and quality of substance abuse treatment services provided.

In times of budget shortfalls and cutbacks, and spiraling correctional costs, substance abuse services are often eliminated or scaled down, and are seen as dispensable relative to other health and security services. At the same time, many correctional systems have begun to experiment with privatized, or partially privatized health care services as a way of limiting liability and containing costs. However, unless substance

abuse treatment services are specifically listed as deliverables in these contracts, it is unlikely that the private provider would offer these services.

STANDARDS FOR SUBSTANCE ABUSE TREATMENT IN PRISONS AND JAILS

Legal Standards

While the courts have consistently rejected a general constitutional right to substance abuse rehabilitation or treatment in correctional facilities , [37] case law indicates that inmates do have limited rights to substance abuse treatment in prisons and jails . [15,38] If conditions in a correctional facility demonstrate "deliberate indifference" to inmates' serious medical needs[3], then substance abuse treatment might be court-ordered to be made available as part of the remedy. For instance, [40] the court found that conditions in a Rhode Island prison were below constitutional standards, and linked the prison's failure to identify inmates with substance dependence problems to increased prison drug trafficking, increased risk of suicide, and overall deterioration of prison conditions. Consequently, the prison was ordered by the court to implement substance abuse treatment services that met minimal professional organization and federal agency standards, including those that address the medical needs associated with substance abuse withdrawal.

While there is a limited legal mandate for substance abuse treatment services in jails and prisons, inmates' rights to medical treatment for withdrawal (i.e., detoxification) and other serious medical problems associated with substance abuse have consistently been upheld . [15,38,41-43] Thus, when an inmate enters the correctional system while on methadone maintenance for heroin addiction, the courts have required medical

[3] Serious medical needs are defined as those diagnosed by a physician as requiring treatment or those that are so obvious that a layperson would easily recognize the necessity for medical attention (*Pace v. Fauver*, 1979)

management of methadone withdrawal, but have not required continuance on methadone. [38] Due in part to the need to identify and treat potentially life-threatening consequences of substance dependence, including withdrawal, screening for substance abuse in prisons and jails appears to have a stronger legal basis than does substance abuse treatment. [39,44-46]

Several lawsuits have also supported the need for correctional personnel in jails and prisons to be adequately trained to distinguish between intoxication from substance abuse and serious medical illnesses, which can mimic symptoms of intoxication (Vaughn, 1999). For instance, [47] in one case, an individual was arrested for suspicion of drunk driving, placed in jail, and was mistakenly thought to be highly intoxicated. As a result, diagnosis and treatment of a cerebral hemorrhage was delayed, which contributed to his death three days later. In a similar case, [48] an individual was arrested for public drunkenness and was placed in jail overnight for observation. The next day he was still unconscious, was hospitalized, and died of encephalitis several days later. In both of these cases the defendants (jails systems) were found liable, demonstrating the importance of adequate screening, examination, and close observation of inmates who appear to be intoxicated, in order to rule out serious health problems. [49]

Legal cases in which correctional healthcare personnel have been found guilty of malpractice and/or negligence for <u>denial</u> of medical care include the following categories: "(1) denial of treatment for known and serious medical conditions, (2) denial of medical care to physically disabled prisoners, (3) denial of care from failure to diagnose health problems, and (4) denial, to prisoners, of access to their prison medical records". [49] Legal cases in which correctional healthcare personnel have been found guilty of

malpractice and/or negligence for delay of medical care include the following: "(1) delay in diagnosis of life-threatening illnesses, (2) delay in treatment that results in hospitalization, and (3) delay in administering appropriate medications". [49] These findings from case law underscore the importance of attending to the serious medical consequences of substance abuse, including prompt medical screening to rule out other serious diseases when inmates appear intoxicated, and to address the risk of medical complications related to overdose or withdrawal.

Several new court decisions[50-51)] have defined Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) as religious-based activities. [15] Thus, jails and prisons that coerce inmate participation in AA or NA (e.g., with institutional privileges and/or desirable security classifications) have been found to violate the First Amendment of the U.S. Constitution, which prohibits government-sponsored religious activities. Legal liability can be avoided by either removing coercive requirements to participate in such programs, or by providing nonreligious treatment alternatives. [15,38]

Professional Standards

A number of professional standards have been developed to guide the implementation of correctional substance abuse treatment services. [15,38,52] Standards developed by the National Commission on Correctional Health Care (NCCHC) and by the American Correctional Association (ACA) are among the most comprehensive and are generally more explicit and demanding than the legal standards described in the previous section. The following substance abuse services are listed as "essential" by the NCCHC [53-55] for both jails and prisons:

- Management of intoxication and withdrawal, including medical supervision, use of written policies and procedures, and provisions for transferring inmates experiencing severe overdose or withdrawal to a licensed acute care facility.
- A comprehensive health assessment (including substance abuse history) conducted within 7 days after arrival in prison or within 14 days after arrival in jail.
- A mental health evaluation conducted within 14 days of arrival in jail or prison, including an evaluation of substance abuse history (these services are listed as "essential" for prisons and as "important" for jails).

The NCCHC lists the following correctional services as "important" under its "Standards for Inmates With Alcohol or Other Drug Problems" for both jails and prisons: [53-55]

- Written policies and actual practice to identify, assess, and manage inmates with substance abuse problems.
- Opportunities for counseling provided to all inmates with histories of substance abuse problems.
- Accreditation of counselors who provide substance abuse treatment services.
- Use of existing community resources, including referral to specified community resources on release.

Although similar to the standards developed by the NCCHC, the ACA's standards for jail and prison substance abuse treatment [56-58] give more detail regarding appropriate programmatic elements. [15] The ACA's standards also call for mandatory substance abuse screening of inmates during the initial health examination, and offer the following additional recommendations regarding the use of standardized procedures for substance abuse screening and assessment:

- Inclusion of a standardized battery of instruments.
- Screening and sorting procedures, including clinical assessment and reassessment.
- Assessment and referral for substance abuse program assignment that is appropriate to the needs of individual inmates, including a standardized "needs assessment" administered to investigate the inmate's substance abuse history and identification of problem areas.
- Drug testing and monitoring.
- Routine diagnostic assessment.

ACA's guidelines for substance abuse treatment in jails and prisons [56-58] include the following:

- Development of individualized treatment objectives and goals by a multidisciplinary treatment team.
- Addressing counseling and drug education needs.
- Medical exams to determine health needs and/or observational requirements.
- Development of an aftercare discharge plan with the inmate's involvement.
- Use of staff who are trained in substance abuse treatment to design and supervise the program.
- Written treatment philosophy with goals and measurable objectives.
- Inclusion of recovered alcoholics/addicts as employees or volunteers, with appropriate training.
- Inclusion of self-help groups as adjuncts to treatment.
- Efforts to motivate addicts to receive treatment through incentives such as housing and clothing preference.
- Provision of a range of treatment services.
- Culturally sensitive treatment approaches.
- Pre-release relapse prevention education including risk management.
- Pre-release and transitional services, including coordination with community programs to ensure continuity of supervision and treatment.

Practice Guidelines

In addition to legal and professional standards for substance abuse treatment in correctional settings (see above), practice guidelines have been established by the American Psychiatric Association [59] that provide detailed recommendations related to clinical treatment for alcohol, cocaine, and opioid use disorders. Although these do not specifically address issues unique to correctional settings, they provide more comprehensive practice guidelines than the standards outlined above by the NCCHC and the ACA. APA's guidelines [59] give an overview of treatment principles and alternative treatments for these disorders, as well as recommendations regarding assessment,

psychiatric management, pharmacology, psychosocial treatments, treatment planning and treatment settings, and legal/confidentiality issues.

A more recent set of guidelines [60] focuses on psychiatric services in jails and prisons, and includes brief but useful sections on treatment of substance-involved offenders, including those with co-occurring mental and substance use disorders. These guidelines note that, in jails, acute conditions can be present at the time of detainment, including intoxication and/or mental disorders. These conditions, along with the stress of arrest and confinement, increase the risks of suicidal and violent behavior, underscoring the need for adequate and timely screening and assessment procedures for both mental health and substance use disorders. For example, substance intoxication noted during mental health screening should immediately trigger screening for depressed mood and/or suicide potential. This is particularly important since most suicides in jail settings occur within 24-48 hours after admission, and are often carried out by inmates who are intoxicated or experiencing substance withdrawal. Psychiatrists should be involved in ensuring that screening for the above issues is adequate.

APA also calls for the integration of substance abuse services with mental health services in correctional settings, and notes that co-occurring disorders are often undetected in correctional settings due to inadequate screening and assessment procedures. Non-detection of one co-occurring disorder can lead to exacerbation of symptoms in the other type of disorder and increase the risk of suicide, recurrence of psychiatric symptoms, substance use relapse, and criminal recidivism. Thus, detection of one type of disorder should immediately trigger screening for the other type of disorder, and necessitates sharing and coordination of information across security and treatment

staff and throughout the system. Treatment of co-occurring disorders must be comprehensive, integrated, and individualized, with adequate follow-up in the community.

SCREENING AND ASSESSMENT IN CORRECTIONAL SETTINGS

Screening and assessment procedures are an important part of any substance abuse treatment system in jails and prisons. Accurate screening and assessment can allow offenders to be routed efficiently into an appropriate level of treatment, while screening out those who do not need such treatment. Screening and assessment are particularly important in criminal justice populations, which have high prevalence rates of substance abuse and other co-occurring disorders. Without adequate screening and assessment, offenders are likely to be released to the community with their substance use and co-occurring disorders untreated, leading to a high likelihood of criminal recidivism and substance relapse. While there are currently no comprehensive national standards for substance abuse screening and assessment in jails and prisons, there are several important publications that offer useful guidelines. [20,61-63]

Screening typically refers to use of brief measures that rapidly identify offenders with a potential need for substance abuse treatment, and thus informs determinations about eligibility for services. Screening also informs decisions regarding referral for more comprehensive assessment. Assessment typically requires more training than screening, and often includes a comprehensive battery of instruments and completion of a psychosocial interview in order to determine suitability for placement in available levels of treatment [20]

Key domains to be addressed during screening and assessment in correctional settings include the following: [20]

- Substance use history, including current patterns of use, treatment history, and acute symptoms, including the need for detoxification.
- Criminal history.
- Personality traits related to criminality (e.g., features of psychopathy).
- Mental health issues, including suicide potential, acute symptoms, prescribed. psychiatric medications, and treatment history.
- History of abuse or trauma as a victim or perpetrator.
- Motivation and readiness for treatment.
- Physical health, including pregnancy status, acute conditions, and presence of infectious disease (especially STD's, HIV/AIDS, hepatitis, and tuberculosis).
- Education and literacy.
- Physical disabilities.
- Housing issues.
- Relationships with family members, significant others, and dependents.

Motivation and readiness for treatment is useful to examine in order to match offenders to an appropriate level and intensity of treatment, and to provide specific interventions to address motivational issues. [64] Non-confrontational motivational interviewing techniques [65] are discussed later in this chapter, and can be used during assessment interviews to promote inmate motivation and engagement in treatment. Screening instruments that can be used to identify offenders' motivation and readiness for treatment include the University of Rhode Island Change Assessment Scale, [66-67] the Stages of Change Readiness and Treatment Eagerness Scale, [68] and the Circumstances, Motivation, Readiness, and Suitability Scale. [69]

Offenders, as well as substance abusers in general, may be more likely than other populations to attempt to conceal or distort information obtained from self-report screening and assessment measures. [70-73] Malingering in prison settings has been found to range from 15%[74] to 46%. [75] In pretrial jail settings, malingering has been found to

range from 8% [76] to 37%.[77] Rogers [71] review of the malingering literature found a range of 15-17% in forensic settings. Internal factors which might contribute to inaccurate self-report include antisocial, psychopathic, paranoid, or manipulative traits, "denial" as part of their substance use disorder, a lack of readiness to participate in treatment, and poor memory due to higher likelihood of neurological problems associated with substance use disorders and/or head trauma. [70,78]

External factors contributing to offender motivation to report inaccurately include malingering substance use problems to obtain treatment for non-clinical reasons. For example, inmates may inaccurately report a substance abuse history in an attempt to obtain reduced sentences, favorable housing arrangements, or institutional privileges. [70] On the other hand, some inmates will exaggerate symptoms of real distress, because they believe that a high level of severity is required to obtain services. Additionally, inmates may attempt to conceal substance abuse due to the fear of legal consequences (i.e., adjudication and sentencing). Staff who provide screening and assessment in jails and prisons should be familiar with the potential reasons and motivations for inaccurate reporting of information.

The accuracy of self-report information can be enhanced through the use of effective screening and assessment measures. Several measures have been found to be more effective than others in classifying offenders who are suitable for treatment . [63] These include the combined Addiction Severity Index (ASI)- Drug Use Section [79] and the Alcohol Dependence Scale, [80] the Simple Screening Instrument, [81] and the Texas Christian University Drug Screen. [82] The 16-item SSI was developed by a panel of national experts who selected items from existing validated substance abuse screening

instruments. The SSI is most useful when the purpose of screening is to maximize identification of inmates who have substance use disorders (e.g., during initial screening for treatment eligibility). The TCUDS is a 19-item instrument that was developed through funding from the National Institute of Drug Abuse, and is most useful when the purpose of screening is to maximize identification of inmates who do not require substance abuse treatment. The SSI and the TCUDS are quick and easy to administer and score, can be completed in either a paper-and pencil or interview form, and are available in the public domain. Both measures outperformed the SASSI-2 [83] and a range of other screening instruments in identifying substance use disorders among incarcerated offenders. [63]

The accuracy of screening and assessment can be further improved by obtaining collateral information from friends, associates, or family members of offenders, and from review of medical and other correctional records (e.g., to assess the inmate's history of drug screens in institutional and community settings). Some screening and assessment measures also include scales to measure malingering, as well as defensive, random, and/or inconsistent responding. Two such measures that have been validated for correctional populations include the Minnesota Multiphasic Personality Inventory-2 [84] and the Structured Interview of Reported Symptoms. [85]

SUBSTANCE ABUSE TREATMENT APPROACHES IN CORRECTIONS

Motivational Interviewing

Motivational interviewing (MI; also referred to as Motivational Enhancement Therapy or MET) is a counseling approach designed to increase client motivation and readiness to change, [65,86] and is based in part upon the Transtheoretical Model of Stages

of Change. [64] MI is designed to help move clients from earlier stages (i.e., pre-contemplation and contemplation) to later stages of change (i.e., preparation and action) by increasing their motivation, commitment, and readiness for change. MI has a strong research base to support its effectiveness in community treatment, and has also been adapted successfully with criminal justice populations . [87] Many offenders with substance use disorders are initially coerced into treatment by the court or correctional system, and may have little internal motivation to stop their addictive behaviors. MI encourages exploration and resolution of ambivalence about behavioral change, which is particularly useful in work with substance-involved offenders, who have high initial resistance to change. [87] Thus, MI is useful to assist inmates in developing readiness and commitment to make lifestyle changes.

Cognitive Skills Training and Criminal Thinking

Cognitive skills interventions such as Rational Emotive-Behavioral Therapy [88] have emerged as significant treatments for a range of psychosocial disorders. These approaches recognize that behavioral problems are often rooted in distorted thought processes, such as rationalizations to engage in criminal or addictive behavior. Cognitive skills interventions provide self-monitoring skills to identify maladaptive thoughts and learn how to replace or restructure them. These interventions have been successfully adapted for use with substance-abusing offenders. [89] For example, treatment activities have focused on modifying longstanding criminal thinking patterns and values that are closely linked with substance abuse problems.

Criminal thinking problems are characterized by denial, minimalization, externalization of blame, and self-centeredness, distortions that are similar to those used

by substance abusers. For example, offenders may attribute their criminal behavior solely to their substance abuse disorder, to which the individual has fallen "victim". [90] Specific treatment strategies include self-assessment exercises, regular self-monitoring through completion of "thinking logs", and identification of different types of criminal thought patterns.

Relapse Prevention

The relapse prevention model [91] was developed to help prevent substance abusers who have become abstinent from returning to full-blown use. Because many substance-abusing offenders have a history of multiple prior relapses and unsuccessful attempts to maintain abstinence, relapse prevention is an important component of treatment in criminal justice settings, and has been implemented effectively in such settings . [92] For many substance-involved offenders, incarceration may provide one of the first opportunities to experience an extended period of abstinence. Despite having relapsed frequently in the past, offenders are not typically aware of how the relapse process occurs and typically have few strategies for dealing with their high risk situations for relapse.

Relapse prevention techniques combine elements of cognitive therapies, behavioral skill training, and lifestyle change to assist offenders in developing effective coping skills to maintain abstinence. Self-management strategies are developed, such as self-assessment of prior relapse episodes and learning ways to counteract relapse antecedents (e.g., negative emotions, drug cravings, social pressure to use, etc.), including learning drug refusal skills. Prior to release, it is important to help offenders develop a relapse prevention plan that may include emergency coping skills used to deal

with unexpected high risk situations, strategies for avoiding high risk situations (including neighborhoods and persons associated with the offender's prior substance abuse), and peer supports such as 12-step groups and sponsors. Relapse prevention plans may also address issues related to living arrangements (e.g., living with known substance abusers), employment, methods to cope with stress, warning signs for relapse, managing cravings and urges to use, and time management to maintain lifestyle balance.

Co-occurring Mental Health and Substance Abuse Disorders

An estimated 3% to 11% of jail and prison inmates have co-occurring substance use and major mental disorders. [9-10,93-95] Incarcerated offenders with co-occurring disorders have more pronounced psychosocial problems than other offenders in areas of employment, social skills and social supports, cognitive functioning, and adjustment to incarceration. [13] Due to the absence of community services for persons with severe and persistent mental illness, and to fragmented mental health and substance abuse service systems, many offenders with co-occurring disorders repeatedly cycle through the criminal justice system. [96]

Co-occurring disorders frequently are undetected in jails and prisons. [60] The resulting lack of treatment for one or both disorders contributes to poor treatment outcomes, [97] which are often misattributed to client resistance, lack of motivation, or to staff or programmatic factors.

The American Psychiatric Association [60] has outlined the following treatment strategies for effective treatment of co-occurring disorders in criminal justice settings:

- Treatment should be integrated and focus concurrently on both substance use and mental disorders.
- Both types of disorders must be considered "primary", and treatment activities should provide greater understanding of how the disorders interact.

- Comprehensive assessment should lead to development of an individualized treatment plan, which should include input from the inmate and family members if available, and should address specific psychosocial problems and skill deficiencies.
- Intensity, length, and types of services should also be tailored to the specific correctional setting.
- Prescribed medications should be administered with caution, due to their potential interaction with substance use. If possible, inmates who have not previously been prescribed psychiatric medications should be provided a reasonable period of detoxification prior to beginning a trial on medication, unless psychotic or suicidal symptoms are present.
- Treatment must be extended into the community, with special attention to discharge/aftercare planning, and should include ways to address ongoing treatment needs, housing and employment needs, reconnection with the family, and development of support networks, including self-help groups.

In the last several years, a number of treatment programs for co-occurring disorders have been developed in state prisons and in the Federal Bureau of Prisons . [13] Typically, such programs provide structured, intensive treatment activities in several phases, with gradually less intensive services provided over time. Phases of treatment often include an orientation phase focused on motivation and engagement in treatment. This is followed by a more intensive treatment phase, with a final phase focused on relapse prevention, discharge planning, and transition services. In-prison co-occurring disorders treatment programs often consist of therapeutic communities (TC's) that are modified to provide a longer period of treatment, a focus on psychoeducational and skill-building approaches, shorter duration of individual and group treatment sessions, and smaller staff caseloads. [13] Such programs are less confrontative and provide more individual counseling and support in comparison to traditional correctional treatment programs. [98-99]

Several programs have also been developed in recent years to divert inmates with co-occurring disorders from jail. [96] Pre-booking jail diversion programs provide

coordination between law enforcement and community mental health and substance abuse treatment agencies and often include mobile crisis response teams that intervene in emergency situations when requested by law enforcement. Post-booking jail diversion programs involve arrangements between courts, defenders and prosecutors, probation agencies, and community mental health/substance abuse treatment agencies to identify and refer offenders who are eligible for community treatment as a condition of their sentence. Post-booking diversion programs help to identify eligible cases, and to negotiate with prosecutors and defense counsel regarding treatment alternatives to incarceration. Common elements of post-booking diversion programs include: (a) screening and assessment of mental and substance use disorders (b) counseling, (c) discharge planning, (d) "boundary spanning" staff who link the mental health, substance abuse, and criminal justice systems, (e) referral to community treatment, and (f) post-release monitoring in the community. [100]

Therapeutic Communities

The Therapeutic Community (TC) approach was developed over 30 years ago as a long-term residential treatment for individuals with chronic and severe drug problems. The TC is based on development of a peer recovery community that promotes behavior change through a variety of social learning experiences . [101] There is considerable research to support the effectiveness of TC's in reducing substance abuse and crime, and many TC's have been implemented effectively in prison settings. [102] Although TC's vary widely in size and client demographics, they feature lengthy involvement in treatment, and have a similar programmatic structure, staffing pattern, theoretical perspective, and daily treatment regimen. [102]

Within TC programs, substance abuse is viewed as a disorder of the whole person, which affects all areas of functioning. TC's focus on development of basic skills (e.g., social skills) that may have never been fully learned, [102] and recovery is seen as involving major changes in lifestyle, behavior, and identity. While offenders usually enter TC's under coercion from the criminal justice system, these programs attempt to instill internal commitment to recovery through peer and staff feedback, and through other self-help and social learning experiences.

CORRECTIONAL SUBSTANCE ABUSE TREATMENT PROGRAMS

Over the past 25 years, a wide range of substance abuse treatment programs have been developed for correctional settings. Such programs are typically more comprehensive in prisons than in jails, as prisons often have more resources, provide longer periods of confinement, and offer a broader range of institutional settings than jails. Although numerous treatment program descriptions are available in the literature for both jails [15,45,103] and prisons, [33,52,104-107] several of the more comprehensive treatment systems are reviewed in the following section.

Federal Bureau of Prisons

The Federal Bureau of Prisons (BOP) has a long history of providing substance abuse treatment. [34] The BOP substance abuse treatment services employ a biopsychosocial approach, which focuses on modification of values, attitudes, and cognitive patterns associated with criminal behavior and substance abuse. Substance abuse treatment is provided at different levels of intensity, followed by post-release transitional services in the community. In order to be eligible for residential treatment, inmates must volunteer and have a DSM-IV diagnosis of substance dependence or abuse.

Participants are housed in units that are isolated from the general prison population. Treatment services are provided for up to 10 months and include at least 500 hours of substance abuse treatment . Services provided include individual and group therapy, as well as psychoeducational approaches to help inmates develop positive coping skills and interpersonal skills, and cognitive restructuring techniques such as Rational Behavior Therapy (RBT). Inmates enrolled in nonresidential treatment services are not separated from the general prison population. Services include individualized assessment and treatment planning, as well as individual and group therapy that addresses relapse prevention and restructuring of cognitive errors associated with criminal behavior and substance abuse.

Florida Department of Corrections

The Florida Department of Corrections (FDC) has provided prison-based substance abuse program services since the 1970's, [15,108-109] which are located in major correctional institutions, as well as work and forestry camps, work release centers, and road prisons.[110] Long-term residential TC's are housed in isolated treatment units and provide 9 to 12 months of services. TC participants are encouraged to earn better jobs, greater privileges and higher status through adhering to community rules and values, full participation in treatment activities, and commitment to recovery goals. Through multiple opportunities to learn from the consequences of their behaviors, these highly structured TC's help inmates to develop personal accountability and responsibility, self-discipline, and consistency. Structured TC activities are provided 7 days per week for a minimum of 60 hours weekly. Several TC's have also been designed for inmates who have co-occurring mental health and substance use disorders. These programs range in

duration from 8 to 12 months, and include specialized psychoeducational skills groups, psychiatric medication and consultation services, group and individual counseling, relapse prevention, and transition services.

Intensive outpatient services are also provided by the FDC over a period of 4 to 6 months. At least 12 hours of program activities are provided weekly for a minimum of 4 days per week. In addition, non-intensive outpatient and reentry/transitional services are available and are intended primarily for inmates who were not released from custody after completion of the intensive outpatient or residential programs.

Oregon Department of Corrections

The Oregon Department of Corrections (ODC) has developed a linked, computerized tracking system to ensure that inmates are matched to services that meet their needs. [15] Three TC's provide services for inmates with severe substance use disorders and extensive criminal histories. Inmates are admitted to these programs during the last 9 to 12 months of their incarceration, so that they may transition directly from treatment to the community. These TC's have small staff caseloads and provide approximately 30 hours of services per week. One TC provides specialized treatment for sex offenders with substance abuse disorders, while the other two are designed for inmates with severe substance use disorders, high levels of criminality, and moderately severe co-occurring mental disorders.

Two additional TC's have been modified to meet the needs of inmates with co-occurring mental disorders. These programs utilize a slower pace of treatment and provide fewer hours of core services per week (12 to 15 hours) than the other TC's. The ODC also operates three Pre-Release Day Treatment Programs that are available to

inmates during the last 6 to 7 months of their sentence. These programs provide 12 to 15 weekly hours of treatment services, and feature a bilingual, bicultural Spanish/English program that admits primarily Spanish-speaking inmates. In order to increase the likelihood of inmate involvement in aftercare services, these programs also facilitate "in-reach" linkage services with substance abuse treatment staff in the community, who establish contact with inmates prior to release.

CORRECTIONAL TREATMENT OUTCOME RESEARCH

A large number of prison and jail treatment outcome studies have been conducted, as summarized in several recent reviews. [15,22,24,111] These studies provide strong evidence for the effectiveness of prison-based TCs [112-118] and other intensive prison-based treatment programs [119-120] in reducing relapse and recidivism. A recent meta-analysis of the correctional treatment literature also indicates the effectiveness of long-term prison-based TC's in reducing criminal recidivism.[111] The meta-analysis found that approaches such as cognitive-behavioral therapies, methadone maintenance, and 12-step programs are promising approaches, but require additional research to establish their effectiveness in correctional settings. The study did not support the effectiveness of boot camps and "drug-focused group counseling" programs. One recent study indicated that offenders diagnosed with Antisocial Personality Disorder had positive outcomes similar to those of other offenders, following enrollment in community-based TC programs. [121-122]

Compared to the relatively large body of outcome research evaluating prison substance abuse treatment programs, far fewer studies have focused on jail-based treatment programs. An inherent difficulty in conducting research in jails is that

treatment programs are typically much shorter than those in prisons, which limits the type of services and program models that can be examined. Further, many inmates released from prison are subsequently followed on parole, while people are released from jails to a wide array of settings and systems (e.g., state prison, probation), and many are lost to further contact. Nevertheless, a number of studies provide consistent evidence for the effectiveness of jail substance abuse treatment programs in reducing substance use relapse and criminal recidivism, and in extending the length of time that participants remain arrest-free in the community. [103,123-130]

Research indicates that involvement in post-release community treatment services improves the likelihood of positive outcomes for both prison and jail treatment participants. [112-114,116,131-133] Additionally, longer treatment duration appears to improve outcomes for participants in both prison [134-135] and jail programs. [103,127,136-137] The optimal length of treatment may be somewhat shorter in jails (1.5 to 5 months) [127,137] than in prisons (9 to 12 months); [135] although more research is needed in this area.

The cost-effectiveness of intensive prison TC programs was demonstrated in a recent study, [138] although only when post-release aftercare treatment was provided. Intensive TC services were also found to be the most cost-effective for offenders who are at high risk of criminal recidivism. Jail treatment programs have also been found to yield considerable cost savings related to reductions in criminal recidivism and re-incarceration. Annual savings are estimated at $156,000 to $1.4 million per program. [125,139] Because there are numerous potential outcome variables to examine, treatment efficacy research is challenging, and it is hazardous to recommend programs solely on the basis of cost effectiveness. Nevertheless, the consistently positive findings from the

correctional outcome literature indicate that these programs are a wise investment, and reflect sound public policy.

IMPLEMENTATION OF PRISON AND JAIL TREATMENT SERVICES

There are numerous challenges in implementing correctional substance abuse treatment services in correctional settings. [15,140] Some correctional and treatment staff view substance abuse as a "moral weakness" rather than a biobehavioral problem that is amenable to treatment. As such, substance abuse treatment is seen by these staff as ineffective or merely delaying inmates' inevitable return to drugs and crime. Rationalization of criminal behavior is also a key component of ingrained criminal value systems, [89-90] and treatment participants are often suspected of using their prior substance abuse experiences to rationalize and minimize the importance of criminal behavior. In reality, intensive substance abuse treatment programs in jails and prison can effectively identify and change patterns of criminal thinking and behaviors, and in this capacity are similar to long-term residential treatment programs in the community.

Program Funding and Administrative Support

Only limited funding and staff support are provided to many substance abuse programs in jails and prisons. For example, a national survey found that volunteer staff outnumbered salaried staff by a 2:1 ratio within jail treatment programs. [29] Treatment in many correctional settings consists primarily of 12-step programs (e.g., AA or NA groups) or other peer support and peer-directed activities. [52] In many other settings, programs that previously had adequate funding to support comprehensive treatment have been stripped of funding due to budget cutbacks, or lack of administrative support.[15] Administrative support may be compromised through transfer or retirement of facility

administrators (e.g., prison wardens or superintendents), or through changes in political leadership at the state or local level. In many jails and prisons, professional advancement of correctional staff is contingent on their routine transfer to different units within the facility, or to other institutions. [141] Although this practice provides exposure to a range of different institutional settings, it can also undermine the stability and support for treatment programs. In attempts to overcome this problem, several treatment programs have worked closely with correctional administrators to develop a new professional "tier" for correctional officers that allows for specialized training and permanent assignment to substance abuse treatment units.[141]

Structural Challenges

Recruitment of professional staff with training and experience in substance abuse treatment is often difficult in correctional settings. Correctional facilities are often sited in rural, remote areas that are underserved by health care professionals, and that are far from educational institutions. Some correctional systems provide substance abuse treatment services through contract providers, who are sometimes better able to recruit staff to these remote locations. Due to their location and undesirable working conditions, staff turnover is a frequent problem in many prison systems and jails. Research indicates that this turnover reduces the stability and effectiveness of correctional treatment programs, particularly when this occurs among experienced staff and in more recently established programs. [141-142] Staff burnout and morale can also be problematic in correctional settings. [20]

An isolated housing unit is of vital importance in delivering effective substance abuse services in jails and prisons. [143] Treatment gains established by program

participants are sometimes undermined by inmates who are not enrolled in treatment, and treatment participants who are not separated from the general inmate population are subject to the corrosive effects of their attitudes, values, and behaviors. [20] Participants in correctional treatment are sometimes ostracized by "general population" inmates, and under these conditions it is quite difficult to establish a cohesive therapeutic environment. Effective correctional treatment programs typically include living quarters, dining area, and recreational activities that are isolated from the general correctional population. [13,15]

One general disadvantage to providing treatment in correctional institutions is that inmates are not exposed to the same environment (e.g., stressors, high risk situations) as when they return to the community. Although it is difficult to realistically simulate some situations in jails and prisons, drug coping skills can be taught and rehearsed through repeated practice. Therapeutic Communities (TC's) in correctional settings also provide an important opportunity for extensive peer and staff feedback related to ingrained patterns of "criminal thinking" and antisocial behavior.

Most jails and prisons were not designed architecturally to address the specific needs of substance abuse treatment services. [20] As a result, many treatment programs must share meeting rooms with educational and other correctional services. Program space is often not "soundproof", and staff offices and meeting rooms are often located outside the main housing unit. Treatment services must fit within the regimented schedule of the institution, including daily "counts", in which all inmates are required to return to their cells. In many cases, inmates may select or be assigned to other programs (e.g., vocational and educational services, work assignments) that compete directly with substance abuse treatment, despite clear evidence of an inmate's substance abuse

problems. Incentives such as wages or early release that are provided for involvement in institutional employment are often unavailable for participants in substance abuse treatment.

Transition to the Community

One of the most significant obstacles to effective substance abuse treatment services in correctional settings is the absence of coordinated aftercare and transition services in the community. [15,52,144] A national survey of jail treatment programs found that only 44% of programs offered these services upon release. [29] Similarly, few prisons provide comprehensive discharge planning and transition services. Although jails and prisons appropriately view their primary mission as ensuring inmate security within the institution, substance-involved offenders are very likely to relapse and return to the justice system if they don't receive ongoing treatment in the community. [92,116] The most effective correctional treatment programs are those that combine treatment in the institution with treatment for at least three months following release to the community [115-116,132]

A related issue is that many inmates are released to the community with no further criminal justice supervision (e.g., probation or parole), and are unlikely to enter and remain in treatment under these conditions. One solution is to provide early release from correctional facilities with treatment involvement required as a condition of probation or parole supervision. Case management services can provide an important bridge to assist in successful reintegration of offenders to the community. [20] These services are often initiated while the inmate is still in jail or prison, with community treatment staff and/or case managers visiting the institution to begin planning for involvement in ongoing

treatment, peer support programs, transitional housing, vocational and educational services, and continuation of medications and other health care needs. [144] A recent initiative funded by the U.S. Department of Justice is designed to develop reentry partnerships to assist drug-involved offenders in the transition to the community. [145] These partnerships will establish linkages between correctional institutions, courts, community treatment agencies, community supervision services, law enforcement, other faith-based and neighborhood organizations, and other ancillary services.

Maintaining Professional Boundaries

Providing substance abuse services in jails and prisons requires that treatment staff maintain the trust of both inmates and correctional staff and administrators, [143,146] which can be challenging at times to achieve. Inmate participants in treatment tend to value the advice of staff who have experienced addiction and recovery, and who are willing to talk about these experiences. In contrast, correctional staff frequently express mistrust of former addicts, and are trained not to discuss their own problems, including those related to alcohol and drug abuse. This practice stems in part from the need for correctional staff members to maintain emotional distance between themselves and inmates, so as to ensure objectivity and fairness in dealing with inmates. Taken to the extreme, the need to maintain distance from inmates can lead to coldness, disrespect, and tension between staff and inmates. For treatment staff working in jails and prisons, it is important to assist correctional staff to see addicts as human beings deserving of respect and even empathy. On the other hand, inmates must never doubt that clinicians are corrections employees, and will carry out their responsibilities despite their respect for the inmates they treat.

Inmates sometimes attempt to gain the allegiance of treatment staff, [147] or to compromise or manipulate treatment staff. [148-149] For example, inmates may offer a secret on the condition that it not be repeated to others. If the secret is one that would legally require a report (e.g., planned escape, child abuse, etc.) the staff must decide between breaking a promise and breaking the law. When an inmate offers to trade information for an absolute promise of confidentiality, the answer should always be "no." Basic guidelines for correctional treatment staff include avoiding lying, avoiding promises that can't be kept, and ensuring the confidentiality of selected information. [147]

Relationships Between Security and Treatment

Conflicts inevitably arise in jails and prisons between security and treatment staff, due to different perspectives on institutional safety, rehabilitation, sanctions, and the purpose of incarceration. [141,147,149-150] It is important for staff working in jails and prisons to understand and appreciate these different professional cultures, values, and missions. [151] Unfortunately, security has somehow become synonymous with punishment, and the misuse of this word is unfortunate. Security should mean safety for everyone who lives, works, or visits a jail or prison.

Experienced and competent correctional leaders know that correctional facilities are safest when the inmates are productively engaged, and therefore support treatment services. By the same token, experienced clinicians know that little learning or growth takes place unless the inmates are safe, and that institutional safety is the job of all paid staff within the correctional institution. By contributing to the institution's security, treatment staff are not betraying their clients, but are actually providing more effective

services. [20] When a jail or prison is not secure (i.e., unsafe), the most likely victims of violence are other inmates.

In addition to their traditional security obligations, correctional staff can make important contributions to treatment programs. Correctional staff have more frequent daily contact with inmates than treatment staff, and can provide valuable insights related to treatment planning, as well as information regarding inmate attitudes, functioning, and participation in community activities. [150] In some facilities, correctional officers help to lead skills training groups, and are involved in community meetings, treatment planning, and discharge planning activities. [147,152]

When conflicts arise with correctional officers or correctional administrators, treatment staff should avoid the temptation to view one side as "right" or "wrong. [20,150] Treatment staff should recognize that their perspective is different than that of correctional staff, and that the objective of implementing treatment services is not to overcome the legitimate need of correctional administrators to preserve the security of the institution, but to find creative ways to meet inmates' needs in ways that contribute to the welfare and safety of the facility. [150,153] By taking such a stance, treatment staff will quickly begin to be viewed as important institutional assets by administrators and correctional officers. In fact, treatment coordinators often become an integral part of the leadership team of correctional institutions. [153] In contrast, treatment staff who view their role as one of protecting inmates from the institution and its custody staff will soon become marginalized and ineffective.

The best course of action in resolving conflict between treatment and custody staff is often some type of compromise between the two positions. [20] Before any

negotiation can occur, the respective sides must understand each other's legitimate concerns. This process will often lead to a third course of action that is seen as appropriate by both security and clinical staff, especially when it is clear that both groups share a commitment to safety within the institution. When forced to choose between the interests of treatment and security, correctional administrators will necessarily opt for enhanced security. Fortunately, most treatment programs are designed to support, rather than to compete with the goals of institutional security, and are recognized as among the safest, cleanest, and quietest units within jails and prisons. [21] Effective correctional administrators are typically strong advocates for substance abuse treatment and other related inmate programs, because these services help to create a safer institution. [150,154]

Some jail and prison treatment programs have found that use of joint coordinators from both treatment and corrections systems promotes more effective implementation of services. [143] Joint coordinators can serve as an effective "bridge" between staff from both systems, and are engaged in program planning, debriefing critical incidents, training, and program modification. Cross-training activities involving substance abuse treatment, corrections, and mental health and other health care staff are quite useful in developing shared values and commitment to support correctional treatment programs. [78,150,155]

CONCLUSION

Prison and jail populations have grown tremendously over the past two decades as a result of an influx of drug-involved offenders to the criminal justice system. Well over half of jail and prison inmates have significant substance abuse problems, although most have never participated in a comprehensive treatment program. Incarceration provides a

significant opportunity to initiate treatment services for those with severe alcohol and drug problems. However, the treatment capacity in jails and prisons has not kept pace with the rising number of drug-involved inmates. In fact, our nation's correctional systems are now treating only a small fraction of inmates who need services.

Many existing correctional treatment programs are limited to self-help and peer support activities (e.g., AA and NA groups), and are inadequate to address the pronounced behavioral, emotional, and psychiatric problems that are common among this population, and often do not provide key skills (e.g., employment, problem-solving, relapse prevention, interpersonal/social) that are necessary to make lifestyle changes and to maintain sobriety in the community. Although evidence-base substance abuse treatment techniques are available for female inmates and inmates with co-occurring mental disorders, few specialized programs in jails and prisons have been developed for these populations. Moreover, few services are available in most correctional systems to assist drug-involved inmates in making the difficult transition back to the community, and to ensure that offenders are enrolled in ongoing services once they are released from custody.

Several existing program models in prisons and jails have been developed that feature a comprehensive treatment approach and a continuum of services from the correctional institution to the community. Convergent research findings during the past decade indicate that jail and prison treatment of sufficient intensity and duration (e.g., TC programs) can effectively reduce criminal recidivism and substance abuse in the community. An important corollary to these findings is that involvement in community treatment following participation in jail or prison is critical in ensuring the long-term

maintenance of positive outcomes related to recidivism and substance abuse. Preliminary evidence suggests that jail and prison treatment programs are cost effective and pay significant dividends to society.

Further research is needed to examine alternatives to traditional TC treatment programs in jails and prisons, including those that are of high intensity, but moderate duration (i.e., 4-6 months). Research is also needed to identify methods of matching offenders with the appropriate type, duration, and intensity of treatment to maximize the clinical and financial benefits. Additional work is also needed to examine outcomes of specialized programs designed for "high risk" inmates, such as those with co-occurring mental disorders. Several new reentry programs were recently funded by the U.S. Department of Justice that will help determine the effectiveness of specialized case management services and other linkages to community treatment. Several reentry drug courts are also being implemented in sites around the country, and offer the promise of better coordination and monitoring of the transition process.

This chapter has highlighted the overwhelming need for substance abuse treatment services in correctional settings; the shortfall of services provided compared to need is almost impossible to exaggerate. Further, while the failure to provide substance abuse treatment services may save money in the short-term, in the long-term it is a wasteful and ineffective public policy. Because correctional substance abuse treatment services are not required by existing case law, they have not been implemented to the same degree as mental health or other program services. However, it is of paramount importance that substance abuse treatment be made a top priority in our institutions and

in our communities. To ignore this unmet need will only guarantee communities that are less safe and more wasteful of public resources and human lives.

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