COMMONWEALTH of VIRGINIA

Department of Criminal Justice Services

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January 6, 2014

The Honorable S. Chris Jones, Chairman
House Appropriations Committee
P.O. Box 406
General Assembly Building
Richmond, VA 23219

The Honorable Walter A. Stosch, Chairman
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Delegate Jones and Senator Stosch:

Attached is a report on "Jail Prisoner Re-entry and Substance Abuse Programs", as directed by Item 393, I. of Chapter 806, 2013 Acts of the Assembly.

Please contact me with any questions.

Sincerely,

Garth L. Wheeler

Attachment

cc: Dick Hickman
Paul Van Lenten, Jr.

Jail-Based Substance Abuse Programs

DCJS

January 2014

www.dcjs.virginia.gov

Jail-Based Substance Abuse Programs

Authority

Item 393 #3c of the 2013 Budget Bill directed that the Department of Criminal Justice Services "shall review jail prisoner reentry and substance abuse programs that have demonstrated a record of effectiveness in reducing offender recidivism. The review shall include, but not necessarily be limited to, an assessment of the effectiveness of the Kingdom Life Ministries program at the Richmond City Jail, and a determination of the costs and benefits associated with this program and consideration of whether jail prisoner reentry and substance abuse programs that have a demonstrated record of effectiveness should be expanded. Copies of this review shall be provided to the Secretary of Public Safety and the Chairmen of the Senate Finance and House Appropriations Committees by January 1, 2014."

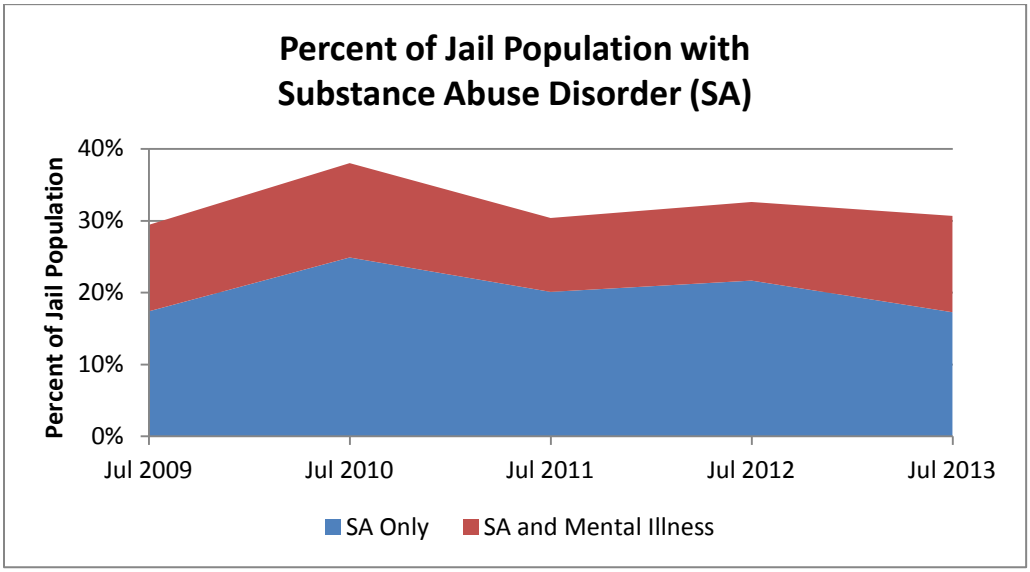
Reentry programs were discussed in more detail in a separate report, *Review of Virginia's Pre- and Post-Incarceration Services,* www.leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD3382013/$file/RD338.pdf. This report will focus more specifically on jail-based substance abuse programs that have demonstrated effectiveness in reducing offender recidivism.

Jail-Based Substance Abuse Programs

The Virginia Compensation Board conducts a survey of jails each year to gather information on inmates with mental illness (http://scb.virginia.gov/docs/2013mentalhealthreport.pdf). Some information on inmates with substance abuse disorders is also gathered, and included in the annual report.

The most common treatment provided for inmates with substance abuse disorders is group substance abuse treatment, which the Compensation Board's 2013 *Mental Illness in Jails Report* defines as: "Meeting of a group of individuals with a substance abuse clinician for the purpose of providing psycho education about various substance abuse topics and/or to provide group feedback and support with regard to substance abuse issues. Examples could include AA meeting, NA meeting, or relapse prevention groups."

In July 2013, for the 58 (out of 64) local and regional jails that responded to the Compensation Board's survey, 30.7% of the jail population had a known or suspected substance abuse disorder, almost of half of whom had a co-occurring mental illness. Figure 1 presents the trends in these data since 2009. For the past several years, about 30% of jail inmates had a substance abuse need recognized by survey respondents.



Unfortunately, according to the Compensation Board survey results, only about 20% of inmates with a substance abuse disorder receive group substance abuse treatment. It may be that others are receiving other services not counted in this survey; group substance abuse treatment is the only substance abuse service included in the Compensation Board survey.

To provide additional data on jail substance abuse programs, DCJS is currently surveying jails regarding their substance abuse populations and treatment services. Data from this survey are not ready at this time, but the results will be published when the study is complete.

There is little question that substance abuse services for offenders are needed. As the National Institute on Drug Abuse (NIDA) reports:

Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources. Treatment is the most effective course for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems

– Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide (NIDA, 2012)

Principles of Drug Abuse Treatment for Criminal Justice Populations

NIDA produced a guide describing the treatment principles and research findings regarding substance abuse treatment in correctional settings. That document, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (2012), identifies 13 key principles to guide programs, quoted below. A copy of the guide can be found in Appendix A.

1. **Drug addiction is a brain disease that affects behavior.** Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicted persons are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite the consequences.

2. **Recovery from drug addiction requires effective treatment, followed by management of the problem over time.** Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. **Treatment must last long enough to produce stable behavioral changes.** In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage them as well.

4. **Assessment is the first step in treatment.** A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems, establish whether problems exist in other areas that may affect recovery, and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

5. **Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.** Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem-solving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Tailored treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. **Drug use during treatment should be carefully monitored.** Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress.

7. **Treatment should target factors that are associated with criminal behavior.** "Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior, such as feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to accept responsibility for one's actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. **Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.** The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements, as well as that person's changing needs, which may include housing and child care; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and re-entry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment

providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. **Continuity of care is essential for drug abusers re-entering the community.** Offenders who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant after release, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration. *Continuing drug treatment in the community is essential to sustaining these gains.*

10. **A balance of rewards and sanctions encourages pro-social behavior and treatment participation.** When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers," such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

11. **Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.** High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. **Medications are an important part of treatment for many drug abusing offenders.** Medicines such as methadone, buprenorphine, and extended-release naltrexone have been shown to reduce heroin use and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. **Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.** The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and

State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate health care services, encourage compliance with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

- *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (NIDA, 2012)

Programs Shown to Be Effective

A number of programs have demonstrated success in treating substance-abusing offenders. The Substance Abuse and Mental Health Services Administration (SAMHSA) produced the National Registry of Evidence-based Programs and Practices (NREPP), "a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination" (NREPP website, 2013). Using the NREPP, a number of programs were identified as having demonstrated success in a correctional setting. A selection of those programs is listed below. A more complete list of programs, and more information on the ones included below, can be found at: www.nrepp.samhsa.gov/Index.aspx.

The NREPP summary report for each of the listed programs, generated by the NREPP website, is included in Appendix B.

Correctional Therapeutic Community for Substance Abusers

- *NREPP Description:* "Correctional Therapeutic Community (CTC) for Substance Abusers is an in-prison residential treatment intervention for incarcerated offenders who have histories of multiple drug-involved arrests and chronic substance abuse, are eligible for the in-prison work release program, and are 6 months from prison release."

- *NREPP Report of Findings:* "From prison release to the 3-year follow-up, participants in the intervention group were less likely than those in the control group to be rearrested ($p = .003$). This group difference was associated with a small effect size (odds ratio = 1.71)."

Forever Free

- *NREPP Description:* "Forever Free is a drug treatment program for women who abuse drugs and are incarcerated. The intervention aims to reduce drug use and improve behaviors of women during incarceration and while they are on parole."

- *NREPP Report of Findings:* "In a study of outcomes for 180 women 1 year after their release from prison, 8% of Forever Free participants reported drug use in the past 30 days, compared with 32% of the comparison group ($p = .001$). A total of 50.5% of Forever Free participants reported any drug use in the past year, compared with 76.5% of comparison group participants ($p = .001$)."

Friends Care

- *NREPP Description:* "Friends Care is a stand-alone aftercare program for probationers and parolees exiting mandated outpatient substance abuse treatment. The aftercare program is designed to maintain and extend the gains of court-ordered outpatient treatment by helping clients develop and strengthen supports for drug-free living in the community."

- *NREPP Report of Findings:* "After statistically controlling for demographic characteristics, mental health status, and community involvement, participation in aftercare services was

shown to account for a significant reduction in any opiate and cocaine use during… 6-month follow-up period. Specifically, compared with clients in the control condition, clients assigned to the aftercare condition were nearly one-fourth as likely to report using opiates one or more times ($p < .01$) and one-third as likely to report using cocaine one or more times ($p < .05$)."

Helping Women Recover and Beyond Trauma

- *NREPP Description:* "Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatment programs that, when combined, serve women in criminal justice or correctional settings who have substance use disorders and are likely to have co-occurring trauma histories (i.e., sexual or physical abuse)."

- *NREPP Report of Findings:* "From baseline to the 12-month postparole follow-up, women in the intervention group had a larger decrease in drug use composite scores than their counterparts in the comparison group, after controlling for ethnicity, marital status, and employment ($p < .03$)."

Interactive Journaling

- *NREPP Description:* "Interactive Journaling is a goal-directed, client-centered model that aims to reduce substance abuse and substance-related behaviors, such as recidivism, by guiding adults and youth with substance use disorders through a process of written self-reflection."

- *NREPP Report of Findings:* "In the 12 months after study entry, the percentage of participants rearrested and booked at the [Buncombe County Detention Facility] was lower for the intervention group than the comparison group (51% vs. 66%; $p < .05$)."

Modified Therapeutic Community for Persons With Co-Occurring Disorders

- *NREPP Description:* "The Modified Therapeutic Community (MTC) for Persons With Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use disorders and mental disorders."

- *NREPP Report of Findings:* "At the 12-month postrelease follow-up… relative to control group participants, a significantly smaller percentage of MTC participants reported substance use (56% vs. 31%, $p < .01$), illegal drug use (44% vs. 25%, $p < .05$), and alcohol used to intoxication (39% vs. 21%, $p < .05$)."

Moral Reconation Therapy

- *NREPP Description:* "Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth."

- *NREPP Report of Findings:* "[A]dult male inmates of a short-term county detention center who participated in MRT had a reincarceration rate of 11.3% 1 year after release and 25.3% 2 years

after release. Inmates who did not participate in MRT had significantly higher recidivism rates at 1 year (29.7%; $p < .001$) and 2 years (37.3%; $p < .01$) after release."

- MRT is in use at several of Virginia's drug courts. A recent study by the National Center for State Courts (see section titled "Virginia Programs") showed that Virginia drug court programs using MRT were more successful (lower recidivism) than programs without MRT.

Virginia Programs

A number of sources currently provide substance abuse services to Virginia's jail inmates. These sources are described below.

Drug Treatment Courts in Virginia "provide a variety of services, substance abuse and ancillary, to participants while at the same time holding them accountable by means of drug testing, sanctions and incentives, and frequent contacts with the court and court staff," according to a 2012 report by the National Center for State Courts (NCSC), *Virginia Adult Drug Treatment Courts – Impact Study* (www.courts.state.va.us/courtadmin/aoc/djs/programs/dtc/resources/2012_va_adult_dtc_impact_study.pdf). Findings from the report include:

- Approximately 50% of drug court participants successfully graduate from the program, in line with national trends.
- Those that do not graduate remain with the program for about one year, on average. Graduates average 1.7 years with the program.
- Program graduates averaged 139 drug screens over the course of the program. Although 56% of graduates tested positive at some point in the program, overall 98% of their test results were negative.
- Rearrest rates for drug court participants (including those who did not graduate) were lower than for a matched comparison group (57.2 % vs. 70.4%, a statistically significant difference). These included new arrests that occurred during the program, when participants were under a higher level of supervision.
- A separate report by the NCSC indicates that, "on average, Virginia's Drug Courts save $19,234 per person as compared to traditional case processing" (www.courts.state.va.us/courtadmin/aoc/djs/programs/dtc/resources/virginiadtccostbenefit.pdf)

Although drug courts operate under the authority of the Supreme Court of Virginia, treatment services are generally provided by local community service boards.

Virginia's Community Services Boards (CSBs) serve to facilitate access to community-based mental health and substance abuse services. CSBs are licensed by the Virginia Department of Behavioral Health and Developmental Services, and provide services to jail inmates as well as community residents. In July 2013, CSBs provided 5,935 hours of treatment services (substance abuse and mental health) to jail inmates (*Mental Illness in Jails Report*, Compensation Board, 2013). Historically, 42% of substance abuse referrals to CSBs are from the criminal justice system (DBHDS, 2011).

One of the largest CSBs in Virginia is the Richmond Behavioral Health Authority (RBHA). The RBHA provides jail-based services that include "comprehensive psychosocial/chemical dependency assessment, treatment planning and referral, and case management." The RBHA also provides substance abuse services to offenders on probation and parole, through its Memorandum of Agreement with the Richmond Adult Drug Treatment Court and DOC's District 1 Probation and Parole. "Services include comprehensive psychosocial/chemical dependency assessment, treatment planning, case

management, individual and group counseling, relapse prevention, as well as alcohol and other drug abuse education. Services are provided on-site at the District 1 Probation and Parole and Drug Court Program offices in outpatient, intensive outpatient and day treatment modalities" (www.RBHA.org).

While recidivism analysis is not available for the CSBs as a whole, because they provide drug treatment services for the drug treatment courts, the success of those courts should be seen as – at least in part – a success of community services boards.

The Virginia Prisoner Reentry Program, called PAPIS (Pre-release and Post-incarceration Services), is a coalition of non-profit organizations across the state providing services and guidance to offenders before and after incarceration. The nine active PAPIS programs provide services to adult men and women who are or were incarcerated in Virginia state prisons, local jails, and work release centers. Among the services provided by PAPIS programs is substance abuse assistance and referrals.

Pre-release substance abuse services can include counseling, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and drug/alcohol treatment referrals. After release, PAPIS programs can provide substance abuse counseling, support groups, and treatment referrals, all with the goal of helping offenders make a successful return to their community.

In a recent study, PAPIS-involved offenders were found to have lower 12-month rearrest rates than a matched sample of offenders (32.2% vs. 35.6%, a statistically significant difference).

Other organizations, including faith-based groups, may provide services to jail inmates. For example, at the Richmond City Jail, the Becoming Experienced Liberated Introspective Encouraged Free (BELIEF) Program provides a number of services, including AA and NA, to help change the negative social behaviors that led to offenders' substance abuse and criminal behavior. The Men In Recovery Brotherhood (MIR) is another program focusing on substance abuse recovery, providing AA and NA along with other services. MIR works in conjunction with Kingdom Life Ministries, a peer-based recovery support service that is discussed more fully in the next section.

Peer-Based Recovery: Kingdom Life Ministries

Peer-based recovery support is an emerging approach in addiction studies. It is described here by William L. White, of the Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services:

> Peer-based recovery support is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery…
>
> … *Peer-based* means that the supports and services are drawn from the experience of individuals who have successfully achieved addiction recovery and/or who share other characteristics (for example, age, gender, ethnicity, sexual orientation, co-occurring disorders, prior prison experience, family experience, or other identity-shaping life experiences) that enhance the service recipient's sense of mutual identification, trust, confidence, and safety…
>
> *Recovery support* distinguishes the singular goal toward which all efforts are directed. Recovery… involves three critical elements: 1) sobriety (abstinence from alcohol, tobacco, and unprescribed drugs), 2) improvement in global health (physical, emotional, relational, and ontological—life meaning and purpose), and [3] citizenship (positive participation in and contribution to community life). Support involves the provision of informational, emotional, social, and/or material aid.
>
> *Process* implies that the assistance is not a single event or activity and is relational rather than mechanical, and that continuity of support over the time is central to the desired outcome of long-term recovery…
>
> The phrase experientially credentialed means that the knowledge drawn on to provide P-BRS is acquired through life experience rather than formal education. It is first hand rather than second hand. It means that peer support specialists understand long-term recovery as a "lived experience" and can offer guidance on the nuances of this experience as it unfolds over time… Most, but not all, persons providing P-BRS have experienced recovery personally…
>
> –William L. White (2009)
> *Peer-based addiction recovery support:*
> *History, theory, practice, and scientific evaluation*

Kingdom Life Ministries

Kingdom Life Ministries (KLM), a peer-based recovery support services program at the Richmond City Jail, was recently the subject of an evaluation to determine the program's effectiveness in reducing recidivism and improving substance abuse recovery (Scarbrough, 2012). The jail-based component of the program operates in conjunction with the jail's Men In Recovery (MIR) program. The 2012 evaluation report describes the KLM program:

> "Following a peer-based model, the program is led by those in recovery and provides services for men battling substance abuse, specifically those with an extensive history of criminal behavior including violent offenses. KLM services are executed at four points of impact including a Jail Component, Court Component, Re-entry Preparation Component, and Post-Release Component. Treatment across all four components incorporates core elements including spiritual principles, the AA and NA "way of life," and behavior modification….
>
> "Daily [during the jail component], the program director and other staff members, who are successful in their [own] recovery, become a resident of the tier during sessions and host recovery programs. Each week the program combines several hours of primarily small group sessions and work with readings from Narcotics Anonymous (NA), Alcoholics Anonymous (AA), Bible study, the 12 spiritual principles, and behavior modification.
>
> "Upon release, if the men choose to remain a part of the KLM program, they are provided with housing, food, clothing, peer support, access to employment, transportation, friends, and a loving/caring recovery community. If an individual chooses he can stay surrounded by this way of life for as long as he pleases. The peer-based model is an innovative and unique form that is the cornerstone of this program and movement, which is not readily available in the Central Virginia area."

The KLM program reports that it follows evidence-based practices. Based on a review of the report, it appears the KLM program does meet some of NIDA's "Principles of Drug Abuse Treatment for Criminal Justice Populations," described earlier.

- **"Assessment is the first step in treatment" (NIDA principle 4)**: The report indicates that a needs assessment is "conducted at initial imprisonment." The report does not provide details on this assessment. However, needs-assessments are a critical first step in the process of treatment. (p 169)

- **"Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations" (NIDA principle 5):** While there is no indication that the KLM program tailors its services to individual participants, the peer-based nature of the support services should enhance the program's ability to provide participants with recovery coaches who are suited to their individualized needs and cultural expectations. Additionally, during the Reentry Preparation Component, inmates participate in classes to address deficits they may have in various areas (job skills, relationships, ethics, and more). However, KLM's focus on religious instruction would not make it appropriate for offenders who do not accept the program's theology.

- **"Continuity of care is essential for drug abusers re-entering the community" (NIDA principle 9):** The KLM program provides a continuity of care, including housing, transportation, employment, and other assistance to offenders being released from jail.

- **"Treatment must last long enough to produce stable behavioral changes" (NIDA principle 3):** The KLM program provides support services for a long duration, with the goal of producing stable behavioral changes.

- **"A balance of rewards and sanctions encourages pro-social behavior and treatment participation" (NIDA principle 10):** Based on the evaluation report, KLM seems to provide a system of positive and negative reinforcement, involving the attainment or loss of privileges. (p 102)

- **"Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements" (NIDA principle 8):**The KLM program appears to be well-integrated with the Richmond City Jail, and the sheriff supports the program's goals and methods. According to the evaluation report, "Because of the success of the peer monitoring system, violence in the tier has drastically decreased." (p 102)

Findings: Recidivism

The KLM program evaluator compared the recidivism rate for KLM participants to rates for participants in another program in the jail, the Belief program. The study reports that the statewide recidivism rate for KLM participants was 34%, while the comparison group had a statewide recidivism rate of 52%. For participants who were reincarcerated, the average time to reincarceration for KLM participants was 482 days, compared with 365 days for the comparison program.

However, there are some concerns regarding the recidivism analysis that reduces the strength of the reported results. First, it is not entirely clear how "recidivism" is defined. Although the report states that the definition is "return to prison," at various points the text refers to "arrest records" and "incarceration(s) in any correctional facility in Virginia." Although it appears that this last description is the one actually used, it is not certain.

It is also unclear if the participants in the programs were sentenced inmates, or if they included those in jail awaiting trial. The report states that participants could be "released from KLM" by being bonded out of jail. As the report notes, after release on bond, an offender could return to jail after trial if convicted. In such a case, the report states, that person would be identified as a recidivist, having returned to jail. A return to jail under this condition is generally not considered "recidivism" in correctional literature.

Additionally, the KLM and the Belief programs are not compared on their recidivism rate within a specific, consistent period of time. Instead, the recidivism rates appear to include all recidivism across all time for which data were collected. In such a case, a person recidivating on the third day after release and a person recidivating on the 366th day after release would both be captured by the same rate. While this might seem a more complete measure, it is a difficult one for comparing programs. It is not clear from the study whether participants in the comparison program were tracked as long or longer than participants in the KLM program. For the purposes of comparison, knowing the 30-day recidivism rate for both programs would be more useful.

Also, a substantial portion of the participants appear to have still been incarcerated during some undetermined portion of the time when recidivism was being measured. According to the report (p 151), 8.2% of the KLM participants in the study had not in fact been released from the Richmond City Jail at the time data collection for the project ended. These individuals still seem to be included among the "releases," with regard to measuring recidivism. For participants who had been released from KLM, the report (p 151-152) states that almost 10% were actually transferred to another jail, and almost 25% went to prison. There seems to be no accounting for this additional time imprisoned when measuring recidivism. Although most were eventually released from incarceration, the report states that 6.8% "remained in the custody of the Department of Corrections, or had been transferred to another jail" (p 151). Combining those still in the Richmond City Jail with those still in another jail or at DOC reveals that 15% of the study sample *were unable to recidivate* because they remained incarcerated.

The data for the comparison program is not broken out into the same level of detail, so it is unclear what proportion – if any – of those inmates remained incarcerated throughout the data collection period. However, the report (p 164) notes that the primary difference between KLM and the comparison program is that KLM accepts violent offenders while the comparison group does not. Given that, it is reasonable to assume that the average length of time served for the comparison group is considerably shorter than for KLM, and that comparison participants are less likely to go directly to prison. The result of that difference is that the comparison program participants would be free from incarceration for a larger proportion of the study period, and would therefore be more likely to recidivate, and to recidivate much sooner, than KLM participants. If so, this would call into question the report's assertion that KLM participants recidivate less than the participants of the Belief program.

Findings: Other

Although methodological problems render it unclear how to interpret the reported recidivism results, the report does point out other benefits to the program.

Importantly, the report notes that, under the peer-monitoring system incorporated in the KLM program, violence in that tier of the jail "drastically decreased." Specific numbers are not given in the report, but a press release from the Richmond City Jail states "Prior to the beginning of KLM/MIR, the tier experienced many severe fights, leading to an average of two to three visits to the emergency room each week. This averages 10 visits, or $20,000 a month… Since the beginning of the program, there have been only three minor scuffles on the tier, none of which required a visit to the emergency room. As such, this has saved the jail an additional $840,000 over the study period" (Richmond City Jail, press release, July 9, 2012).

Additionally, the evaluation report includes multiple examples of interview responses that highlight the value of having peer-based recovery support services as part of their treatment. It must be remembered that recovery support is not intended as a treatment in and of itself, but rather as a means of creating an environment in which those suffering from substance abuse disorder have the support they need to fully take advantage of treatment options. Based on the evaluation report, KLM is providing that necessary support system for its participants.

Recommendations

Peer-based recovery support services, such as the KLM program, will likely help those suffering from substance abuse disorders take advantage of treatments available from evidence-based programs.

Virginia should promote the use of evidence-based, jail-focused, substance abuse programs that share the characteristics of effective programs, such as those identified by the SAMHSA's National Registry of Evidence-based Programs and Practices.

Virginia should also consider expanding the drug treatment courts, which have demonstrated their effectiveness. The community services boards, which provide treatment services to those courts, should also receive the resources needed for their activities.

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Appendix A: Principles of Drug Abuse Treatment for Criminal Justice Populations

NIDA
NATIONAL INSTITUTE
ON DRUG ABUSE

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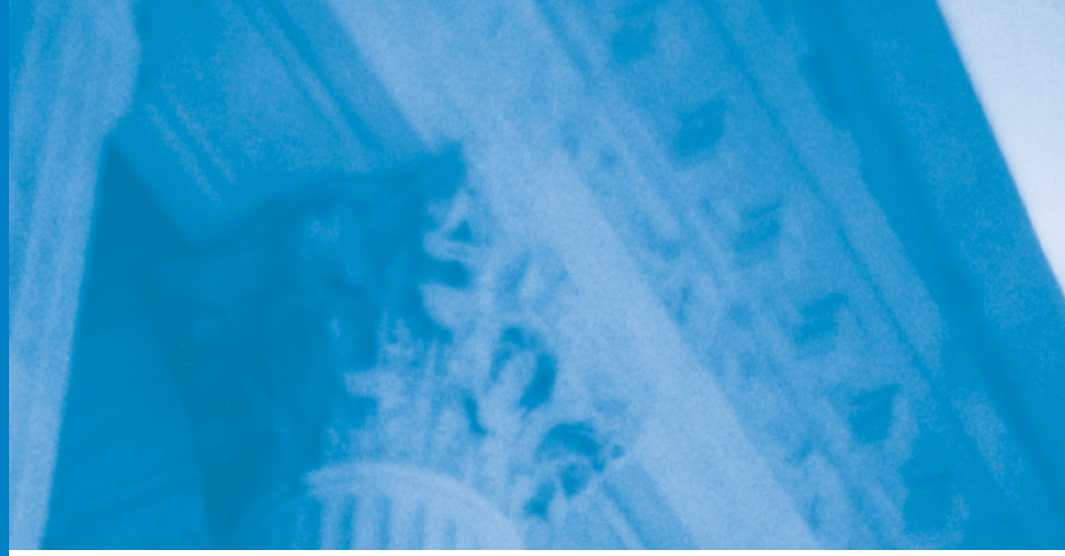

National Institute on Drug Abuse

Principles of Drug Abuse Treatment for Criminal Justice Populations | A Research-Based Guide

National Institutes of Health
U.S. Department of Health
and Human Services

PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS

1. Drug addiction is a brain disease that affects behavior. Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicted persons are at a high risk of relapse to drug abuse even after long periods of abstinence and why they persist in seeking drugs despite the consequences.

2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time. Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. Treatment must last long enough to produce stable behavioral changes. In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more

comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage them as well.

4. Assessment is the first step in treatment.

A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems, establish whether problems exist in other areas that may affect recovery, and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.

Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problemsolving, and skill-building for resisting drug use and criminal behavior. Lessons aimed at supplanting drug use and criminal activities with constructive activities and at understanding the consequences of one's behavior are also important to include. Tailored treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. Drug use during treatment should be carefully monitored.

Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress.

7. Treatment should target factors that are associated with criminal behavior.

"Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior, such as feeling entitled to have things one's own way, feeling that one's criminal behavior is justified, failing to accept responsibility for one's actions, and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements, as well as that person's changing needs, which may include housing and child care; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate post-release services to improve the success of drug treatment and re-entry. Abstinence requirements

may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. Continuity of care is essential for drug abusers re-entering the community.

Offenders who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant after release, such as learning to handle situations that could lead to relapse, learning how to live drug-free in the community, and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior post-incarceration. Continuing drug treatment in the community is essential to sustaining these gains.

10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation.

When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers," such as recognition for progress or sincere effort, can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. Medications are an important part of treatment for many drug abusing offenders.

Medicines such as methadone, buprenorphine, and extended-release naltrexone have been shown to reduce heroin use and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS, are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with Federal and State laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on ways to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate health care services, encourage compliance with medical treatment, and re-establish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

CONTENTS

PREFACE

From the time it was established in 1974, the National Institute on Drug Abuse (NIDA) has supported research on drug abuse treatment for people involved with the criminal justice system.

Findings show unequivocally that providing comprehensive drug abuse treatment to criminal offenders works, reducing both drug abuse and criminal recidivism. The substantial prison population in the United States is attributable in large part to drug-related offenses and is accompanied by high rates of recidivism. As such, it is a matter of public health and safety to make drug abuse treatment a key component of the criminal justice system. Indeed, addressing the treatment needs of substance abusing offenders is critical to reducing overall crime and other drug-related societal burdens, such as lost job productivity and family disintegration.

Scientific research shows that drug abuse treatment can work even when an individual enters it under legal mandate. However, only a small percentage of those who need treatment actually

receive it, and often the treatment provided is inadequate. To be effective, treatment must begin in prison and be sustained after release through participation in community treatment programs. By engaging in a continuing therapeutic process, individuals can learn how to avoid relapse and withdraw from a life of crime.

As reflected in our collaborative Criminal Justice–Drug Abuse Treatment Studies (CJ–DATS) Initiative, NIDA is committed to working across organizational boundaries to improve substance abuse treatment services. Multiple studies from different scientific disciplines have helped us understand the basic neurobiology of addiction, along with what constitutes effective treatment. Now we are at the point where the *implementation* of evidence-based treatment principles is called for within the criminal justice system to improve public health and public safety by reducing both drug use and crime.

This booklet—a complement to NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*—is intended to describe the treatment principles and research findings that have particular relevance to the criminal justice community and to treatment professionals working with drug abusing offenders. It is divided into three main sections: (1) research findings on addicted offenders distilled into 13 essential principles (see pages 1–5), (2) a series of frequently asked questions (FAQs) about drug abuse treatment for those involved with the criminal justice system, and (3) a resource section that provides Web sites for additional information. This booklet and other resources on drug abuse and the criminal justice system are available on NIDA's Web site at *http://www.drugabuse.gov/drugpages/cj.html*.

With the release of this landmark publication's revised edition, we are optimistic that correctional agencies have begun to understand how drug treatment programs are helping achieve public health and safety goals for the Nation.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

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This publication was written by Bennett W. Fletcher, Ph.D., Redonna K. Chandler, Ph.D., and the Office of Science Policy and Communications, National Institute on Drug Abuse.

INTRODUCTION

The connection between drug abuse and crime is well known.

Drug abuse is implicated in at least three types of drug-related offenses: (1) offenses defined by drug possession or sales, (2) offenses directly related to drug abuse (e.g., stealing to get money for drugs), and (3) offenses related to a lifestyle that predisposes the drug abuser to engage in illegal activity, for example, through association with other offenders or with illicit markets. Individuals who use illicit drugs are more likely to commit crimes, and it is common for many offenses, including violent crimes, to be committed by individuals who had used drugs or alcohol prior to committing the crime, or who were using at the time of the offense.

According to 2008 statistics from the Department of Justice's (DOJ's) Bureau of Justice Statistics (BJS), the total correctional population is estimated to be 7.3 million, with more than 5 million individuals on probation or under parole supervision, and drug law violations accounting for the most common type of criminal offense (Glaze and Bonczar 2009). In a survey of State and Federal prisoners, BJS estimated that about half of the prisoners met *Diagnostic and Statistical Manual for Mental Disorders* (DSM) criteria for drug abuse or dependence, and yet fewer than 20 percent who needed treatment received it (Chandler et al. 2009; Mumola and Karberg 2006). Of those surveyed, 14.8 percent of State and 17.4 percent of Federal prisoners reported having received drug treatment since admission (Mumola and Karberg 2006).

Juvenile justice systems also report high levels of drug abuse. In 2008, approximately 10 percent of the estimated 2.1 million juvenile arrests were for drug abuse or underage drinking violations (Puzzanchera 2009). As many as two-thirds of detained juveniles may have a substance use disorder (SUD); female juveniles who enter the system generally have higher SUD rates than males (McClelland et al. 2004a).

Treatment offers the best alternative for interrupting the drug abuse/criminal justice cycle.

Although the past several decades have witnessed an increased interest in providing substance abuse treatment services for criminal justice offenders, only a small percentage of offenders has access to adequate services, especially in jails and community correctional facilities (Taxman et al. 2007; Sabol et al. 2010). Not only is there a gap in the availability of these services for offenders, but often there are few choices in the types of services provided. Treatment that is of insufficient quality and intensity or that is not well suited to the needs of offenders may not yield meaningful reductions in drug use and recidivism. Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources. Treatment is the most effective course for interrupting the drug abuse/criminal justice cycle for offenders with drug abuse problems.

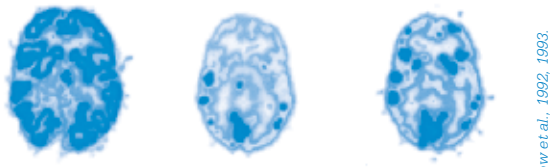
Drug abuse treatment can be incorporated into criminal justice settings in a variety of ways. Examples include treatment in prison followed by community-based treatment after release; drug courts that blend judicial monitoring and sanctions with treatment by imposing treatment as a condition of probation; and treatment under parole or probation supervision. Drug abuse treatment can benefit from the cross-agency coordination and collaboration of criminal justice professionals, substance abuse treatment providers, and other social service agencies. By working together, the criminal justice and treatment systems can optimize resources to benefit the health, safety, and well-being of the individuals and communities they serve.

FREQUENTLY ASKED QUESTIONS (FAQS)

1. Why do people involved in the criminal justice system continue abusing drugs?

The answer to this perplexing question spans basic neurobiological, psychological, social, and environmental factors. The repeated use of addictive drugs eventually changes how the brain functions. Resulting brain changes, which accompany the transition from voluntary to compulsive drug use, affect the brain's natural inhibition and reward centers, causing the addicted person to use drugs in spite of the adverse health, social, and legal consequences (Baler and Volkow 2006; Volkow et al. 2010; and Chandler et al. 2009). Craving for drugs may be triggered by contact with the people, places, and things associated with prior drug use, as well as by stress. Forced abstinence (when it occurs) is not treatment, and it does not cure addiction. Abstinent individuals must still learn how to avoid relapse, including those who may have been abstinent for a long period of time while incarcerated.

Addictive drugs cause long-lasting changes in the brain



Normal | **Cocaine Abuser** (10 days of abstinence) | **Cocaine Abuser** (100 days of abstinence)

Source: Volkow et al., 1992, 1993.

PET scans showing glucose metabolism in healthy (normal) and cocaine-addicted brains. Even after 100 days of abstinence, glucose metabolism has not returned to normal levels.

Potential risk factors for released offenders include pressures from peers and family members to return to drug use and a criminal lifestyle. Tensions of daily life—violent associates, few opportunities for legitimate employment, lack of safe housing, and even the need to comply with correctional supervision conditions—can also create stressful situations that can precipitate a relapse to drug use.

Research on how the brain is affected by drug abuse promises to teach us much more about the mechanics of drug-induced brain changes and their relationship to addiction. Research also reveals that with effective drug abuse treatment, individuals can overcome persistent drug effects and lead healthy, productive lives.

2. Why should drug abuse treatment be provided to offenders?

The case for treating drug abusing offenders is compelling. Drug abuse treatment improves outcomes for drug abusing offenders and has beneficial effects for public health and safety. Effective treatment decreases future drug use and drug-related criminal behavior, can improve the individual's relationships with his or her family, and may improve prospects for employment. In addition, it can save lives: A retrospective study of more than 30,000 Washington State inmates found that during the first 2 weeks after release, the risk of death among former inmates was more than 12 times that among other residents, with drug overdose being the leading cause (Binswanger et al. 2007).

Outcomes for substance abusing individuals can be improved when criminal justice personnel work in tandem with treatment providers on drug abuse treatment needs and supervision requirements. Treatment needs that can be assessed after arrest include substance abuse severity, mental health problems, and physical health. Defense attorneys, prosecutors, and judges need to work together during the prosecution and sentencing phases of the criminal justice process to determine suitable treatment programs that meet the offender's needs. Through drug courts, diversion programs, pretrial release programs that are conditional on treatment, and conditional probation with sanctions, the offender can participate in community-based drug abuse treatment while under criminal justice supervision. In some instances, the judge may recommend that the offender participate in treatment while serving jail or prison time or require it as part of continuing correctional supervision post-release.

3. How effective is drug abuse treatment for criminal justice-involved individuals?

Treatment is an effective intervention for drug abusers, including those who are involved with the criminal justice system. However, the effectiveness of drug treatment depends on both the individual and the program, and on whether interventions and treatment services are available and appropriate for the individual's needs. To alter attitudes, beliefs, and behaviors that support drug use, the drug abuser must engage in a therapeutic change process, which may include medications to help prevent relapse. Longitudinal outcome studies find that those who participate in community-based drug abuse treatment programs commit fewer crimes than those who do not participate (Prendergast et al. 2002; Butzin et al. 2006; and Kinlock et al. 2009).

Outcomes can be improved when criminal justice personnel work in tandem with treatment providers.

4. Are all drug abusers in the criminal justice system good candidates for treatment?

A history of drug use does not in itself indicate the need for drug abuse treatment. Offenders who meet drug dependence criteria should be given higher priority for treatment than those who do not. Less intensive interventions, such as drug abuse education or self-help group participation, may be appropriate for those not meeting criteria for drug dependence. Services such as family-based interventions for juveniles, psychiatric treatment, or cognitive-behavioral interventions for changing "criminal thinking" may be a higher priority for some offenders, and individuals with mental health problems may require specialized services (see FAQ Nos. 6 and 12).

Low motivation to participate in treatment or to end drug abuse should not preclude access to treatment if other criteria are met. Motivational enhancement interventions may be useful in these cases. Examples include motivational interviewing and contingency management techniques, which often provide tangible rewards in exchange for meeting program goals. Legal pressure that encourages abstinence and treatment participation may also help these individuals by improving retention and prompting longer treatment stays.

Drug abuse treatment is also effective for offenders who have a history of serious and violent crime, particularly if they receive intensive, targeted services. The economic benefits in avoided crime costs and those of crime victims (e.g., medical costs, lost earnings, and loss in quality of life) may be substantial for these high-risk offenders. Treating them requires a high degree of coordination between drug abuse treatment providers and criminal justice personnel to ensure that the prisoners receive needed treatment and other services that will help prevent criminal recidivism.

5. Is legally mandated treatment effective?

Often, the criminal justice system can apply legal pressure to encourage offenders to participate in drug abuse treatment; or treatment can be mandated through a drug court or as a condition of pretrial release, probation, or parole. A large percentage of those admitted to drug abuse treatment cite legal pressure as an important reason for seeking treatment. Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Individuals under legal pressure also tend to have higher attendance rates and remain in treatment for longer periods, which can also have a positive impact on treatment outcomes.

Legal pressure can increase treatment attendance and improve retention.

6. Are relapse risk factors different in offender populations? How should drug abuse treatment deal with these risk factors?

Often, drug abusing offenders have problems in other areas. Examples include family difficulties, limited social skills, educational and employment problems, mental health disorders, infectious diseases, and other medical issues. Treatment should take these problems into account, because they can increase the risk of drug relapse and criminal recidivism if left unaddressed.

Stress is often a contributing factor to relapse, and offenders who are re-entering society face many challenges and stressors, including reuniting with family members, securing housing, and complying with criminal justice supervision requirements. Even the many daily decisions that most people face can be stressful for those recently released from a highly controlled prison environment.

Returning to environments associated with drug use may trigger cravings and cause a relapse.

Other threats to recovery include a loss of support from family or friends, which incarcerated people may experience. Drug abusers returning to the community may also encounter people from their lives who are still involved in drugs or crime and be enticed to resume a criminal and drug using lifestyle. Returning to environments or activities associated with prior drug use may trigger strong cravings and cause a relapse. A coordinated approach by treatment and criminal justice staff provides the best way to detect and intervene with these and other threats to recovery. In any case, treatment is needed to provide the skills necessary to avoid or cope with situations that could lead to relapse.

Treatment staff should identify the offender's unique relapse risk factors and periodically re-assess and modify the treatment plan as needed. Generally, continuing or re-emerging drug use during treatment requires a clinical response—either increasing the amount or level of treatment, or changing the treatment intervention.

7. What treatment and other health services should be provided to drug abusers involved with the criminal justice system?

One of the goals of treatment planning is to match evidence-based interventions to individual needs at each stage of drug treatment. Over time, various combinations of treatment services may be required. Evidence-based interventions include cognitive-behavioral therapy to help participants learn positive social and coping skills, contingency management approaches to reinforce positive behavioral change, and motivational enhancement to increase treatment engagement and retention. In those addicted to opioid drugs, agonist/partial agonist medications can also help normalize brain function, and antagonist medications can facilitate abstinence. For juvenile offenders, treatments that involve the family and other aspects of the drug abuser's environment have established efficacy.

Drug abuse treatment plans for incarcerated offenders can facilitate successful re-entry into the community by incorporating relevant transition plans and services. Drug abusers often have mental and physical health, family counseling, parenting, educational, and vocational needs, so medical, psychological, and social services are often crucial components of successful treatment. Case management approaches can be used to provide assistance in obtaining and integrating drug abuse treatment with community services.

8. How long should drug abuse treatment last for individuals involved in the criminal justice system?

While individuals progress through drug abuse treatment at different rates, one of the most reliable findings in treatment research is that lasting reductions in criminal activity and drug abuse are related to length of treatment. Generally, better outcomes are associated with treatment that lasts longer than 90 days, with treatment completers achieving the greatest reductions in drug abuse and criminal behavior. Again, legal pressure can improve retention rates.

A longer continuum of treatment may be indicated for individuals with severe or multiple problems. Research has shown that treatment provided in prison and continued in the community after release can reduce the risk of recidivism to criminal behavior as well as relapse to drug use.

Early phases of treatment help the participant stop using drugs and begin a therapeutic process of change. Later stages address other problems related to drug abuse and, importantly, help the individual learn how to self-manage the drug problem.

Because addiction is a chronic disease, drug relapse and return to treatment are common features of recovery. Thus, treatment may need to extend over a long period across multiple episodes of care.

9. How can rewards and sanctions be used effectively with drug-involved offenders in treatment?

The systematic application of behavioral management principles underlying reward and punishment can help individuals reduce their drug use and criminal behavior. Rewards and sanctions are most likely to change behavior when they are certain to follow the targeted behavior, when they follow swiftly, and when they are perceived as fair. It is important to recognize and reinforce progress toward responsible, abstinent behavior. Rewarding positive behavior is more effective in producing long-term positive change than punishing negative behavior. Indeed, punishment alone is an ineffective public health and safety intervention for offenders whose crime is directly related to drug use (Leukefeld et al. 2002). Nonmonetary rewards such as social recognition can be as effective as monetary ones. A graduated range of rewards given for meeting predetermined goals can be an effective strategy.

Contingency management strategies, proven effective in community settings, use voucher-based incentives or rewards, such as bus tokens, to reinforce abstinence (measured by negative drug tests) or to shape progress toward other treatment goals, such as program session attendance or compliance with medication regimens. Contingency management is most effective when the contingent reward closely follows the behavior being monitored. An intervention

tested by CJ-DATS researchers, called "Step'n Out," used a contingency management approach whereby criminal justice staff monitored specific behaviors (e.g., abstinence, employment searches, and counseling attendance) and rewarded individuals who met agreed-upon goals with social acknowledgement (e.g., congratulatory letter from parole supervisor) and small material incentives (e.g., partial payment for clothes for job interviews). This approach improved parolees' attendance at integrated community parole and addiction treatment sessions, as well as increased use of treatment and individual counseling services (Friedmann et al. 2009).

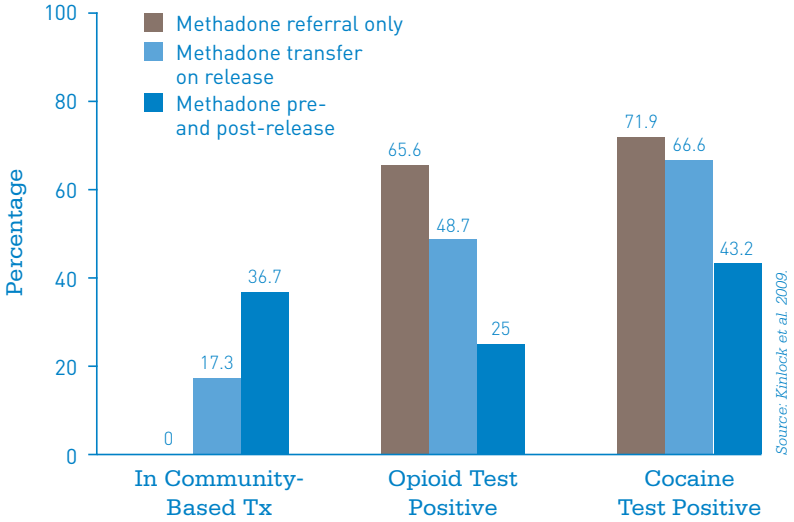
Graduated sanctions, which invoke less punitive responses for early and less serious noncompliance and increasingly severe sanctions for more serious or continuing problems, can be an effective tool in conjunction with drug testing. The effective use of graduated sanctions involves consistent, predictable, and clear responses to noncompliant behavior.

Drug testing can determine when an individual is having difficulties with recovery. The first response to drug use detected through urinalysis should be a clinical one—for example, increasing treatment intensity or switching to an alternative treatment. This often requires coordination between the criminal justice staff and the treatment provider. (Note that more intensive treatment should not be considered a sanction, but rather a routine progression in health care practice when a treatment appears less effective than expected.)

It is important to recognize and reinforce progress toward responsible, abstinent behavior.

Behavioral contracting can employ both rewards and sanctions. A behavioral contract is an explicit agreement between the participant and the treatment provider or criminal justice monitor (or among all three) that specifies proscribed behaviors and associated sanctions, as well as positive goals and rewards for success. Behavioral contracting can instill a sense of procedural justice because both the necessary steps toward progress and the sanctions for violating the contract are specified and understood in advance.

Methadone treatment before and after release from prison increases treatment retention and reduces drug use



At 12 months post-release, offenders who had received methadone treatment in prison and continued it in the community were significantly more likely to enter and stay in treatment and less likely to test positive for opioid and cocaine use than participants who received counseling and referral *to methadone, or those who received counseling with transfer to methadone maintenance upon release.*

10. What is the role of medications in treating substance abusing offenders?

Medications can be an important component of effective drug abuse treatment for offenders. By allowing the brain to function more normally, they enable the addicted person to leave behind a life of crime and drug abuse. Although some jurisdictions have found ways to successfully implement medication therapy, addiction medications are underused in the treatment of drug abusers within the criminal justice system, despite evidence of their effectiveness.

Effective medications have been developed for treating addiction to opiates/heroin and alcohol:

- **Opiates/Heroin**. Long-term opiate abuse results in a desensitization of the brain's opiate receptors to endorphins, the body's natural opioids. Opioid agonist/partial agonist medications, which act at the same receptors as heroin, morphine, and endorphins, tend to be well tolerated and can help an individual remain in treatment. For example, methadone, an opiate agonist, reduces the craving that otherwise results in compulsive use of heroin or other illicit opiates. Methadone treatment has been shown to be effective in decreasing opiate use, drug-related criminal behavior, and HIV risk behavior. Buprenorphine is a partial agonist and acts on the same receptors as morphine (a full agonist), but without producing the same level of dependence or withdrawal symptoms. Suboxone is a unique formulation of buprenorphine that contains naloxone, an opioid antagonist that limits diversion by causing severe withdrawal symptoms in addicted users who inject it to get "high." It has no adverse effects when taken orally, as prescribed.

Medications can be an important component of effective drug abuse treatment for offenders.

An alternative approach, in previously detoxified opiate users, is to use an antagonist medication that blocks the effects of opiates. Naltrexone has been available for more than 2 decades, but poor compliance in the face of severe cravings and addiction has undermined its benefits. An extended-release injectable formulation of naltrexone (Vivitrol) was recently approved by the U.S. Food and Drug Administration (FDA) for treating opioid addiction. Vivitrol requires dosing every month rather than daily, which stands to improve treatment adherence.

- **Alcohol**. Disulfiram (also known as Antabuse) is an aversion therapy that induces nausea if alcohol is consumed. Acamprosate, a medication that helps reduce alcohol craving, works by restoring normal balance to the brain's glutamate neurotransmitter system. Naltrexone (and now Vivitrol), which blocks some of alcohol's pleasurable effects and alcohol craving, is also approved by the FDA for treatment of alcohol abuse.

11. How can the criminal justice and drug abuse treatment systems reduce the spread of HIV/AIDS, hepatitis, and other infectious diseases among drug abusing offenders?

Individuals involved in the criminal justice system have disproportionately high rates of substance use disorders and infectious diseases, including HIV/AIDS. In fact, 14 percent of HIV-infected individuals in this country pass through the criminal justice system each year (Spaulding et al. 2009). Other infectious diseases, such as hepatitis B, hepatitis C, and tuberculosis, also are pervasive in the criminal justice system.

This overrepresentation also provides an opportunity to integrate treatment and improve outcomes for both substance use disorders and infectious diseases. Research shows that treatment for drug abuse can lessen the spread of infectious diseases by reducing high-risk behaviors like needle-sharing and unprotected sex (Metzger et al. 2010). Identifying those who are HIV+ and starting them on HAART treatment could not only improve their health outcomes but also decrease HIV spread (Montaner et al. 2010).

The prevalence of AIDS is approximately five times higher among incarcerated offenders than in the general population.

It is imperative that offenders with infectious diseases be linked with community-based medical care prior to release. Offenders often have difficulty negotiating access to health services and adhering to complex treatment protocols following release from prison and jail. One study found that simply helping HIV-infected inmates complete the paperwork required to get their prescriptions filled upon release significantly diminished treatment interruption, although improvement was still needed, since fewer than half had filled their prescriptions within 2 months of release (Baillargeon et al. 2009).

Community health, drug treatment, and criminal justice agencies should work together to offer education, screening, counseling, prevention, and treatment programs for HIV/AIDS, hepatitis, and other infectious diseases to offenders returning to the community.

12. What works for offenders with co-occurring substance abuse and mental disorders?

It is important to adequately assess mental disorders and to address them as part of effective drug abuse treatment. Many types of co-occurring mental health problems can be successfully addressed in standard drug abuse treatment programs. However, individuals with serious mental disorders may require an integrated treatment approach designed for treating patients with co-occurring mental and substance use disorders.

Much progress has been made in developing effective medications for treating mental disorders, including a number of antidepressants, antianxiety agents, mood stabilizers, and antipsychotics. These medications may be critical for treatment success with offenders who have co-occurring mental disorders such as depression, anxiety disorders, bipolar disorder, or schizophrenia. Cognitive-behavioral therapy can be effective for treating some mental health problems, particularly when combined with medications. Contingency management can improve adherence to medications, and intensive case management may be useful for linking severely mentally ill individuals with drug abuse treatment, mental health care, and community services. A specialized type of treatment—Modified Therapeutic Communities (MTCs)—incorporates features of traditional Therapeutic Communities with a special focus on addressing co-occurring mental health conditions.

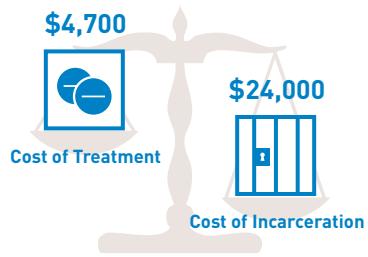
13. Is providing drug abuse treatment to offenders worth the financial investment?

In 2007, it was estimated that the cost to society of drug abuse was $193 billion (National Drug Intelligence Center [NDIC], 2011), a substantial portion of which—$113 billion—is associated with drug-related crime, including criminal justice system costs and costs borne by victims of crime. The cost of treating drug abuse (including health costs, hospitalizations, and government specialty treatment) was estimated to be $14.6 billion, a fraction of these overall societal costs (NDIC, 2011). Drug abuse treatment is cost effective in reducing drug use and bringing about related savings in health care. Treatment also consistently has been shown to reduce the costs associated with lost productivity, crime, and incarceration across various settings and populations. The largest economic benefit of treatment is seen in avoided costs of crime (incarceration and victimization costs). Providing methadone treatment to opioid-addicted prisoners prior to their release, for example, not only helps to reduce drug use but also avoids the much higher imprisonment costs for drug-related crime (see figure).

economic benefit of treatment is seen in avoided costs of crime.

Even greater economic benefits result from treating offenders with co-occurring mental health problems and substance use disorders. Residential prison treatment is more cost effective if offenders attend treatment post-release, according to research (Martin et al. 1999; Butzin 2006). Drug courts also convey positive economic benefits,

Treating addiction in the criminal justice system is cost-effective



The cost of methadone treatment averages around $5,000 a year, compared to approximately $24,000 for State and Federal prisons to keep people confined. Reducing the number of people incarcerated for drug use can net huge savings in economic and social costs.

Sources: Zarkin et al. 2008 and Warren et al. 2008.

including participant-earned wages and avoided incarceration and future crime costs.

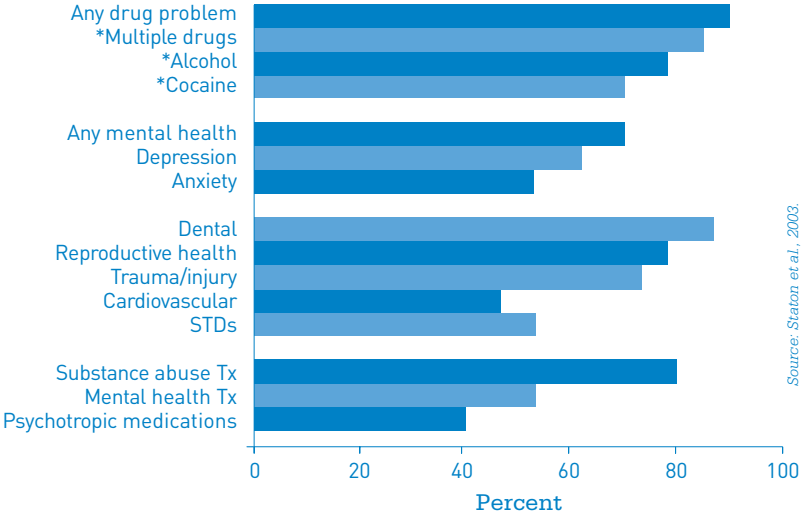
14. What are the unique treatment needs of women in the criminal justice system?

Although women are incarcerated at far lower rates than men, the number and percentage of incarcerated women have grown substantially in recent years. Between 2000 and 2008, the number of men in prisons and jails grew by only 5 percent, while the number of incarcerated women grew by about 15 percent (Sabol et al. 2010). Women in prison are likely to have a different set of problems and needs than men, presenting particular treatment challenges that may call for tailored approaches (Greenfield et al. 2007) (figure).

Incarcerated women in treatment are significantly more likely than incarcerated men to have severe substance abuse histories, co-occurring mental disorders, and high rates of past treatment for both; they also tend to have more physical health problems (Staton et al. 2003; Messina et al. 2006). Approximately 50 percent of female offenders are likely to have histories of physical or sexual abuse, and women are more likely than men to be victims of domestic violence. Past or current victimization can contribute to drug or alcohol abuse, depression, post-traumatic stress disorder, and criminal activity.

Treatment programs serving both men and women can provide effective treatment for their female patients. However, gender-specific programs may be more effective for female offenders, particularly those with histories of trauma and abuse (Pelissier et al. 2003). Female offenders are more likely to need medical and mental health services, child care services, and assistance in finding housing and employment. Following a comprehensive assessment, women with mental health disorders should receive appropriate treatment and case management, including victim services as needed. For female offenders with children, parental responsibilities can conflict with their ability to participate in drug treatment. Regaining or retaining custody of their children can also motivate mothers to participate in treatment. Treatment programs may improve retention by offering child care services and parenting classes.

Incarcerated women have high rates of substance abuse, mental disorders, and other health problems



*Note: Graph shows lifetime percentages except for multiple drugs, alcohol, and cocaine, which are the percentage reporting use in the 30 days prior to incarceration. (N=60)

15. What are the unique treatment needs of juveniles in the criminal justice system?

The U.S. Department of Justice's Office of Justice Programs reports a high rate of drug use among juvenile detainees. One study, for example, found that 77 percent of criminal justice-involved youth reported substance use (mainly marijuana) in the past 6 months, and nearly half of male and female juvenile detainees had a substance use disorder (McClelland et al. 2004a; McClelland et al. 2004b).

Arrest rates for drug-related crimes also remain high among juveniles. A recent report showed that of the estimated 2.1 million juvenile arrests in 2008, approximately 10 percent were for drug abuse or underage drinking violations (Puzzanchera 2009).

Juveniles entering the criminal justice system can bring a number of serious problems with them—substance abuse, academic failure,

emotional disturbances, physical health issues, family problems, and a history of physical or sexual abuse. Girls make up nearly one-third of juvenile arrests, a high percentage of whom report some form of emotional, physical, or sexual abuse. Effectively addressing these problems requires their gaining access to comprehensive assessment, treatment, case management, and support services appropriate for their age and developmental stage. Assessment is particularly important, because not all adolescents who have used drugs need treatment. For those who do, there are several points in the juvenile justice continuum where treatment has been integrated, including juvenile drug courts, community-based supervision, juvenile detention, and community re-entry.

Effective treatment of juvenile substance abusers often requires a family-based treatment model.

Families play an important role in the recovery of substance abusing juveniles, but this influence can be either positive or negative. Parental substance abuse or criminal involvement, physical or sexual abuse by family members, and lack of parental involvement or supervision are all risk factors for adolescent substance abuse and delinquent behavior. Thus, the effective treatment of juvenile substance abusers often requires a family-based treatment model that targets family functioning and the increased involvement of family members. Effective adolescent treatment approaches include multisystemic therapy, multidimensional family therapy, and functional family therapy. These interventions show promise in strengthening families and decreasing juvenile substance abuse and delinquent behavior.

Juvenile offenders

Virtually every juvenile offender should be screened for drug abuse and mental disorders, and receive an intervention:

- Treatment for those who are dependent on alcohol or drugs, or mentally ill.
- Drug abuse prevention for those who are not.
- HIV prevention or treatment as needed.

RESOURCES

Many resources are available on the Internet. The following are useful links:

General Information

NIDA Web site: www.drugabuse.gov

General Inquiries: NIDA Public Information Office 301–443–1124

Federal Resources

Bureau of Justice Assistance (BJA) Substance Abuse Programs	www.ojp.usdoj.gov/bja/programs/substance_abu.html
Bureau of Justice Statistics (BJS) Statistics on Drugs and Crime	http://bjs.ojp.usdoj.gov/content/dcf/contents.cfm
Center for Substance Abuse Treatment (CSAT) Substance Abuse and Mental Health Services Administration (SAMHSA)	http://www.samhsa.gov/about/csat.aspx

Federal Resources (continued)

Federal Bureau of Prisons (BOP) Substance Abuse Treatment	www.bop.gov/inmate_programs/substance.jsp
National Criminal Justice Reference Service (NCJRS)	www.ncjrs.gov
National Institute on Alcohol Abuse and Alcoholism (NIAAA)	www.niaaa.nih.gov
National Institute of Corrections (NIC)	www.nicic.org
National Institute of Justice (NIJ)	www.ojp.usdoj.gov/nij
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Office of Applied Studies (OAS) Substance Abuse and Mental Health Services Administration (SAMHSA)	www.samhsa.gov/data
Office of Justice Programs (OJP)	www.ojp.usdoj.gov
Office of Juvenile Justice and Delinquency Prevention (OJJDP)	www.ojjdp.ncjrs.org

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For More Information

For more information about other research-based publications on drug abuse and addiction, visit NIDA's Web site at **www.drugabuse.gov**, or contact the *DrugPubs* Research Dissemination Center at 877–NIDA-NIH (877-643-2644; TTY/TDD: 240–645–0228).

Appendix B: Select Program Descriptions from the National Registry of Evidence-based Programs and Practices

Correctional Therapeutic Community for Substance Abusers

Correctional Therapeutic Community (CTC) for Substance Abusers is an in-prison residential treatment intervention for incarcerated offenders who have histories of multiple drug-involved arrests and chronic substance abuse, are eligible for the in-prison work release program, and are 6 months from prison release. It is designed to reduce any type of rearrest, increase abstinence from illicit drug use, reduce illicit drug use relapse, and increase postrelease employment among participants. The 6-month intervention is provided as part of a work release program in which participants become residents in an in-prison work release therapeutic community facility separated from the rest of the prison population.

During the first 3 months of CTC for Substance Abusers (i.e., 4-6 months from prison release), residents participate in the first three phases of a five-phase therapeutic community model of treatment for substance abuse:

- Phase 1 of the treatment model consists of assessment, evaluation, and orientation into a CTC. Each new resident is assigned a primary counselor who conducts a needs assessment.
- Phase 2 emphasizes the residents' active involvement in the CTC, including such activities as morning meetings, group therapy, one-on-one interaction, confrontation of other residents who are not motivated toward substance abuse recovery, and nurturing of newer residents. Residents begin to address their own issues related to substance abuse and criminal activity in group sessions and during one-on-one interactions.
- Phase 3 stresses role modeling and overseeing the working of the CTC on a daily basis (with the support and supervision of the clinical staff). So residents develop a strong sense of community, they are organized into a hierarchical structure by roles and job functions, which are associated with strict behavioral expectations and corresponding rewards or sanctions. The rewards or sanctions are applied jointly by staff (many of whom are former offenders or recovering adults who formerly abused substances and act as role models) and residents who act as role models for newer residents.

During the final 3 months of CTC for Substance Abusers (i.e., the 3 months leading up to prison release), residents are permitted to work in the community as part of the work release program while participating in the last two phases of the treatment model:

- In phase 4, residents are prepared for gainful employment and participate in mock interviews; attend seminars on job seeking; and receive information on how to dress, prepare a resume, make the best impression on a potential employer, develop relationships with community agencies, and look for ways to further educational or vocational abilities.
- Phase 5 includes reentry into the community and consists of the residents becoming gainfully employed in the community while continuing to live in the in-prison work release therapeutic community facility and serving as a role model for those in earlier stages of treatment. Also during this phase, residents open a bank account and begin to budget for housing, food, and utilities.

After prison release, participants are encouraged to enter aftercare treatment programming (e.g., outpatient counseling, group therapy) in a therapeutic community environment, under the supervision of parole or other surveillance program.

The primary clinical staff members who deliver CTC for Substance Abusers are typically recovering adults who formerly abused substances and who, ideally, also received treatment in a therapeutic community. These staff members are complemented by counselors who have received formal education. All implementing staff must receive intervention-specific training. In addition, implementation requires mutual cooperation, support, and ongoing communication between intervention staff, correctional security personnel, and the prison warden.

Descriptive Information

Areas of Interest	Mental health promotion Substance abuse treatment
Outcomes	**Review Date: February 2013** 1: Rearrests 2: Abstinence from illicit drug use 3: Illicit drug use relapse 4: Employment
Outcome Categories	Crime/delinquency Drugs Employment

Ages	26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Race/ethnicity unspecified
Settings	Residential Correctional
Geographic Locations	Urban Suburban
Implementation History	CTC for Substance Abusers was first implemented by the Delaware Department of Correction in 1991 in Wilmington, at the New Castle County Work Release Center. By 1995, the intervention had been implemented in Delaware's other two work release centers, in Kent and Sussex Counties. According to the National Institute of Justice national evaluation of the Residential Substance Abuse Treatment for State Prisoners program, more than 50,000 criminal justice clients participated in CTC for Substance Abusers during the period of evaluation. Interested implementers from more than 30 countries have visited the Delaware-based implementation, and the intervention model has been used in Argentina, Australia, Austria, Belgium, Bulgaria, Panama, the Philippines, Romania, Spain, and Thailand. The Delaware-based intervention was evaluated for process and outcome findings (including a 15-year follow-up study), resulting in more than 200 papers, books, and presentations. Two other implementations in the United States (in California and Texas) and one in Australia also have been evaluated.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	CTC for Substance Abusers has been modified to be implemented as a 12- to 18-month residential treatment program for individuals with co-occurring substance use and mental disorders. This program, Modified Therapeutic Community (MTC) for Persons With Co-Occurring Disorders, has been reviewed separately by NREPP.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: February 2013

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Butzin, C. A., Martin, S. S., & Inciardi, J. A. (2005). Treatment during transition from prison to community and subsequent illicit drug use. Journal of Substance Abuse Treatment, 28(4), 351-358.

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

Outcomes

Outcome 1: Rearrests	
Description of Measures	Rearrests were measured by participants' self-report of rearrests and by official arrest records. At each follow-up assessment, participants responded "yes" or "no" to a question asking whether they had been rearrested. Each participant's self-report was cross-checked against arrest records from the Delaware Statistical Analysis Center (SAC) and the Interstate Compact Offender Tracking System (ICOTS), which can be used to track arrests in other States and territories. If a participant reported no rearrests, but the SAC or ICOTS had a record of a rearrest, then the measure was coded as a rearrest. If a respondent reported a rearrest, but there was no official rearrest record in the SAC or ICOTS, the measure was still coded as a rearrest.
Key Findings	In a quasi-experimental field trial, incarcerated offenders who had drug-involved arrests and a history of chronic substance abuse and who were eligible for a work release program (as determined by criminal history and correctional counselor interviews) during the 6 months before prison release were assigned to the intervention or control group. Participants in the intervention group received CTC for Substance Abusers, and those in the control group participated in the standard work release program for the full 6 months before prison release (i.e., working or going to school in the community on weekdays and returning to the in-prison dormitory at night and on weekends). Some participants in the intervention group also received treatment in a prior, in-prison therapeutic community and/or received aftercare treatment programming in a therapeutic community environment following prison release. Assessments occurred at prison release, which coincided with the completion of the 6-month intervention or the standard work release program (i.e., 6 months after study entry), and at 1-, 3-, and 4.5-year follow-ups (i.e., 18, 42, and 60 months after study entry, respectively). Findings included the following: • From prison release to the 3-year follow-up, participants in the intervention group were less likely than those in the control group to be rearrested ($p = .003$). This group difference was associated with a small effect size (odds ratio = 1.71). • From prison release to the 4.5-year follow-up, participants in the intervention group were less likely than those in the control group to be rearrested ($p = .017$). This group difference was associated with a small effect size (odds ratio = 1.61).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.4 (0.0-4.0 scale)

Outcome 2: Abstinence from illicit drug use	
Description of Measures	Abstinence from illicit drug use was assessed through the following: • Self-report of drug use. Participants were asked whether they had used any illicit drugs since the previous assessment, and if so, they were asked to recall when that illicit drug use had first occurred and to report the frequency of that use on a scale ranging from 0 (no use) to 6 (used more than once a day). • Self-report of living situation and associated drug use. Participants were asked to recall where they were living at the time of the previous assessment and to report the frequency of illicit drug use while living there on a scale ranging from 0 (no use) to 6 (used more than once a day). The process was repeated for the next residence until the complete period between follow-up assessments was described by type of residence and frequency of any associated

	illicit drug use. • Urinalysis. Participants were asked to provide a urine sample at each follow-up assessment. The urine sample was tested for the presence of opiates, marijuana, cocaine, barbiturates, phencyclidine, and amphetamines. If none of the measures indicated illicit drug use, the participant was classified as being abstinent through the last available assessment date.
Key Findings	In a quasi-experimental field trial, incarcerated offenders who had drug-involved arrests and a history of chronic substance abuse and who were eligible for a work release program (as determined by criminal history and correctional counselor interviews) during the 6 months before prison release were assigned to the intervention or control group. Participants in the intervention group received CTC for Substance Abusers, and those in the control group participated in the standard work release program for the full 6 months before prison release (i.e., working or going to school in the community on weekdays and returning to the in-prison dormitory at night and on weekends). Some participants in the intervention group also received treatment in a prior, in-prison therapeutic community and/or received aftercare treatment programming in a therapeutic community environment following prison release. Assessments occurred at study entry; at prison release, which coincided with the completion of the 6-month intervention or the standard work release program (i.e., 6 months after study entry); and at 1-, 3-, and 4.5-year follow-ups (i.e., 18, 42, and 60 months after study entry, respectively). Findings included the following: • From prison release to the 3-year follow-up, participants in the intervention group were more than 4 times as likely as those in the control group to be abstinent from illicit drug use ($p < .001$). This group difference was associated with a medium effect size (odds ratio = 4.49). • From prison release to the 4.5-year follow-up, participants in the intervention group were more than 3.5 times as likely as those in the control group to be abstinent from illicit drug use ($p < .001$). This group difference was associated with a medium effect size (odds ratio = 3.54). • Also from prison release to the 4.5-year follow-up, participants in the intervention group had a larger proportion of time abstinent from illicit drug use than those in the control group ($p < .0001$). This group difference was concentrated in the first 3 years following prison release; that is, participants in the intervention group had a larger proportion of time abstinent from illicit drug use than those in the control group from prison release to the 1-year follow-up ($p < .001$) and from the 1- to 3-year follow-up ($p < .001$). From the 3- to 4.5-year follow-up, the difference in proportion of time abstinent from illicit drug use was not significantly different between groups.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.3 (0.0-4.0 scale)

Outcome 3: Illicit drug use relapse	
Description of Measures	Illicit drug use relapse was assessed through the following: • Self-report of drug use. Participants were asked whether they had used any illicit drugs since the previous assessment, and if so, they were asked to recall when that illicit drug use had first occurred and to report the frequency of that use on a scale ranging from 0 (no use) to 6 (used more than once a day). • Self-report of living situation and associated drug use. Participants were asked to recall where they were living at the time of the previous assessment and to report the frequency of illicit drug use while living there on a scale ranging from 0 (no use) to 6 (used more than once a day). The process was repeated for the next residence until the complete period between follow-up assessments was described by type of residence and frequency of any associated illicit drug use. • Urinalysis. Participants were asked to provide a urine sample at each follow-up assessment. The urine sample was tested for the presence of opiates, marijuana, cocaine, barbiturates, phencyclidine, and amphetamines. If any of the measures indicated illicit drug use, the time to initial illicit drug use relapse was determined by the first occurring indicator of drug use. If illicit drug use was reported as first occurring during the residential period, the initial date of that period was used as the time to illicit drug use relapse.

Key Findings	In a quasi-experimental field trial, incarcerated offenders who had drug-involved arrests and a history of chronic substance abuse and who were eligible for a work release program (as determined by criminal history and correctional counselor interviews) during the 6 months before prison release were assigned to the intervention or control group. Participants in the intervention group received CTC for Substance Abusers, and those in the control group participated in the standard work release program for the full 6 months before prison release (i.e., working or going to school in the community on weekdays and returning to the in-prison dormitory at night and on weekends). Some participants in the intervention group also received treatment in a prior, in-prison therapeutic community and/or received aftercare treatment programming in a therapeutic community environment following prison release. Assessments occurred at study entry; at prison release, which coincided with the completion of the 6-month intervention or the standard work release program (i.e., 6 months after study entry); and at 1-, 3-, and 4.5-year follow-ups (i.e., 18, 42, and 60 months after study entry, respectively). From prison release through the 4.5-year follow-up, the time to illicit drug use relapse was longer for participants in the intervention group than for those in the control group (28.8 vs. 13.2 months; $p < .001$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Outcome 4: Employment	
Description of Measures	Employment was measured by self-report. Participants were asked whether they were employed at least 30 hours each week since prison release.
Key Findings	In a quasi-experimental field trial, incarcerated offenders who had drug-involved arrests and a history of chronic substance abuse and who were eligible for a work release program (as determined by criminal history and correctional counselor interviews) during the 6 months before prison release were assigned to the intervention or control group. Participants in the intervention group received CTC for Substance Abusers, and those in the control group participated in the standard work release program for the full 6 months before prison release (i.e., working or going to school in the community on weekdays and returning to the in-prison dormitory at night and on weekends). Some participants in the intervention group also received treatment in a prior, in-prison therapeutic community and/or received aftercare treatment programming in a therapeutic community environment following prison release. Assessments occurred at prison release, which coincided with the completion of the 6-month intervention or the standard work release program (i.e., 6 months after study entry), and at 1-, 3-, and 4.5-year follow-ups (i.e., 18, 42, and 60 months after study entry, respectively). During the follow-up period, the percentage of participants who obtained employment since prison release was higher for the intervention group than the control group (54.6% vs. 45.4%; $p < .01$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	1.7 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	79.9% Male 20.1% Female	73.1% Black or African American 26.9% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
4. Missing data and attrition
5. Potential confounding variables

3. Intervention fidelity 6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Rearrests	3.0	3.0	2.8	0.5	1.8	3.4	**2.4**
2: Abstinence from illicit drug use	3.1	2.5	2.8	0.5	1.8	3.4	**2.3**
3: Illicit drug use relapse	3.1	2.5	2.8	1.9	1.8	3.5	**2.6**
4: Employment	0.0	0.0	2.8	1.9	1.8	3.5	**1.7**

Study Strengths

Self-reported rearrests were cross-checked against State and interstate arrest databases, staff who retrieved database records were blind to study condition assignments, and mismatches between self-reported rearrests and database records were coded conservatively as rearrests, increasing both the reliability and validity of the outcome measure. The self-reported illicit drug use items came from known interview instruments, and self-reported illicit drug use was confirmed by urinalysis at each assessment point, increasing the validity of the outcome measure in the study population. Staff were trained to deliver the intervention using a written protocol for treatment delivery, and the structured nature of correctional facilities adds to the strength of intervention fidelity. The study design benefited from a long, longitudinal follow-up period after prison release, and covariate predictors were tested to rule out some of the potential confounding variables. Statistic modeling of the data was appropriate and included sophisticated analyses such as survival analyses for two of the four outcomes to address successive waves of participants entering into a longitudinal field study and right censoring of the data (i.e., withdrawal of participants before the outcome is observed).

Study Weaknesses

There is no documentation of reliability or validity for the self-report employment measure, and there was no attempt to corroborate self-reported employment with an objective, independent measure of employment, such as a reference check. There was no information on the percentages of intervention group sessions and residential meetings that were rated for fidelity. Missing data were substantial (up to 31%) across the study's follow-up period, and investigators did not model the missing data or compare remaining participants and those lost to attrition on measures at study entry, despite the strong likelihood that the data were not missing at random. Across the follow-up period, there was a moderate amount of missing data handled simply by casewise deletion, despite the possibility that these data were not missing at random. Potential confounds, which make clear interpretations of the outcomes difficult, include the following: nonrandom assignment; lack of an attention control to account for nonspecific treatment elements, such as participant expectations, social desirability, and secondary gain; 3-month differential in access to the outside community between the two study conditions; and the fact that some of the offenders in the intervention group participated in a prior, in-prison therapeutic community and/or participated in an aftercare therapeutic community following prison release.

Readiness for Dissemination

Review Date: February 2013

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

American Correctional Association. (2005). Performance-based standards for therapeutic communities. Lanham, MD: Author.

Center for Drug and Alcohol Studies, University of Delaware. (n.d.). Therapeutic community treatment methodology: Treating chemically dependent criminal offenders in corrections, TC101 [PowerPoint slides]. Newark, DE: Author. Retrieved from www.udel.edu/cdas/correctionalTCProgram/TAslides.pdf

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2006). Therapeutic community curriculum: Participant's manual. Rockville, MD: Author.

Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. (2006). Therapeutic community curriculum: Trainer's manual. Rockville, MD: Author.

Criminal Justice Committee of Therapeutic Communities of America. (1999). Therapeutic communities in correctional settings: The Prison Based TC Standards Development project. Final report of phase II. Washington, DC: Executive Office of the President, Office of National Drug Control Policy. Retrieved from http://www.udel.edu/cdas/correctionalTCProgram/ondcp.pdf

Extensions Curriculum for Therapeutic Communities and Demonstrator Guides

Hooper, R. M., & Empson, G. (n.d.). Substance abuse treatment program; Key, Crest, Aftercare: Program manual. Berlin, MD: Strategic Solutions for Public Safety.

Kressel, D., Zompa, D., & DeLeon, G. (2002, July/August). A statewide integrated quality assurance model for correctional-based therapeutic community programs. Offender Substance Abuse Report, 2(4), pp. 49, 56-59, 64.

The Change Companies. (2004). Residential drug abuse treatment program journal: Criminal lifestyles. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Lifestyle balance. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Living with others. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Orientation. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Rational thinking. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Recovery maintenance. Carson City, NV: Author.

The Change Companies. (2004). Residential drug abuse treatment program journal: Transition. Carson City, NV: Author.

The Change Companies. (2005). Attitude check. Carson City, NV: Author.

The Change Companies. (2010). Introduction to therapeutic community. Carson City, NV: Author.

The Therapeutic Community Training Series: Encounter Groups for Addictions, With Rod Mullen [3-video set]:

- Volume I: Evolution of the Encounter Group
- Volume II: Pitfalls and Solutions
- Volume III: Keys to Fostering Growth

The Therapeutic Community Training Series: The Therapeutic Community, With George DeLeon, PhD [3-video set]:

- Volume I: The Therapeutic Community Perspective
- Volume II: Community as Method
- Volume III: Components of a Generic Therapeutic Community

The Therapeutic Community Training Series: Therapeutic Communities in Prison: A Research Perspective, With Harry Wexler, PhD [Video]

Wexler, H. (1986). Therapeutic communities within prisons. In G. DeLeon & J. T. Ziegenfuss (Eds.), Therapeutic communities for addictions: Readings in theory, research and practice (pp. 227-237). Springfield, IL: Charles C. Thomas Publisher.

Other program materials:

- Correctional Therapeutic Community (CTC) Training: Overview for Those Adopting the Program. Retrieved from http://www.udel.edu/cdas/correctionalTCProgram/trainingoverview
- Intervention Summary Document
- Roadmap to Dissemination Materials

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.8	4.0	3.0	**3.6**

Dissemination Strengths

The required implementation and training materials are easily accessed online and are thorough, easy to read, and easy to understand. The developer provides a list of optional resources that enhance program implementation, including several video sets and high-quality journals. Implementation consultation and ongoing telephone support are available. The developer also provides refresher training upon request. The Performance-Based Standards for Therapeutic Communities book systematically assists implementers in understanding what is needed to obtain accreditation with the American Correctional Association. An outcomes measures worksheet is provided to help the development of quality assurance procedures. Consultation is available to answer questions related to program principles and program evaluation.

Dissemination Weaknesses

No matrix, comprehensive outline, or other overview document is provided to strengthen the presentation of materials and allow implementers to easily understand how the program materials work together and in what sequence they should be used. Although the quality assurance materials provide specific elements that can be used to monitor fidelity to underlying therapeutic concepts and principles, there is no fidelity tool that is specific to this program. Some of the quality assurance resources are old copies of documents and are difficult to read.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Therapeutic Community Curriculum: Participant's Manual	Free	Yes
Introduction to Therapeutic Community	$2.50 each	Yes
Key, Crest, Aftercare: Program Manual	$5 each	Yes
Correctional Therapeutic Community (CTC) Training: Overview for Those Adopting the Program	Free	Yes
Residential Drug Abuse Treatment Program Journals (set of 7)	$34 per set	No
Extensions Curriculum for Therapeutic Communities and Demonstrator Guides (8 topical volumes)	Varies by volume	No
Therapeutic Community Curriculum: Trainer's Manual	Free	Yes
Facilitator's Guide for Interactive Journals for Participants in Residential TC Programs for Incarcerated Adults	Free	No
Encounter Groups for Addictions (3-video set)	$299 per set	No
The Therapeutic Community (3-video set)	$299 per set	No
Therapeutic Communities in Prison: A Research Perspective (video)	$99 each	No
Treating Chemically Dependent Criminal Offenders in Corrections (PowerPoint slides)	Free online, $5 for black-and-white hard copy, or $25 for color hard copy	Yes
Onsite training and implementation consultation for new and experienced implementers	$1,000 per day plus travel expenses	No
Therapeutic Communities Within Prisons	Free	No
Performance-Based Standards for Therapeutic Communities	$28 each	Yes
Therapeutic Communities in Correctional Settings: The Prison Based TC Standards Development Project	Free	No
A Statewide Integrated Quality Assurance Model for Correctional-Based Therapeutic Community Programs	Free	No

Additional Information

If an implementer requests multiple days of onsite training and/or implementation consultation, a reduced daily rate can be negotiated.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Prendergast, M. L., Hall, E. A., Wexler, H. K., Melnick, G., & Cao, Y. (2004). Amity prison-based therapeutic community: 5-year outcomes. Prison Journal, 84, 36-60.

Wexler, H. K., Melnick, G., Lowe, L., & Peters, J. (1999). Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. Prison Journal, 79(3), 321-336.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.udel.edu/cdas/correctionalTCProgram**

Forever Free

Forever Free is a drug treatment program for women who abuse drugs and are incarcerated. The intervention aims to reduce drug use and improve behaviors of women during incarceration and while they are on parole. While they are incarcerated, women participate in individual substance abuse counseling, special workshops, educational seminars, 12-step programs, parole planning, and urine testing. Counseling and educational topics include self-esteem, anger management, assertiveness training, information about healthy versus dysfunctional relationships, abuse, posttraumatic stress disorder, codependency, parenting, and sex and health. The program lasts 4-6 months. Women participate in 4 hours of program activities 5 days per week. After graduation and discharge to parole, women may voluntarily enter community residential treatment. Residential treatment services include individual and group counseling. Some women also participate in family counseling, vocational training/rehabilitation, and recreational or social activities.

Descriptive Information

Areas of Interest	Substance abuse treatment
Outcomes	**Review Date: December 2006** 1: Drug use 2: Parole outcomes 3: Employment after incarceration
Outcome Categories	Crime/delinquency Drugs Employment
Ages	26-55 (Adult)
Genders	Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Correctional
Geographic Locations	No geographic locations were identified by the developer.
Implementation History	Forever Free has been implemented at the California Institution for Women, a female-only State prison in Riverside County, California, since 1991.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: No
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: December 2006

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Prendergast, M. L., Wellisch, J., & Wong, M. M. (1996). Residential treatment for women parolees following prison-based drug treatment: Treatment experiences, needs and services, outcomes. Prison Journal, 76, 253-274.

Study 2

Hall, E. A., Prendergast, M. L., Wellisch, J., Patten, M., & Cao, Y. (2004). Treating drug-abusing women prisoners: An outcomes evaluation of the Forever Free program. Prison Journal, 76, 81-105.

Prendergast, M. P., Hall, E., & Wellisch, J. (2002). An outcome evaluation of the Forever Free Substance Abuse Treatment Program: One-year post-release outcomes. Final report to the National Institute of Justice. Los Angeles: UCLA Drug Abuse Research Center.

Supplementary Materials

Hall, E. A., Baldwin, D. M., & Prendergast, M. L. (2001). Women on parole: Barriers to success after substance abuse treatment. Human Organization, 60, 225-233.

Prendergast, M., Hall, E., Baldwin, D. M., & Wellisch, J. (1999). A qualitative study of participants in the Forever Free Substance Abuse Treatment Program. Report to the California Department of Corrections. Los Angeles: UCLA Drug Abuse Research Center.

Prendergast, M., Hall, E., Wellisch, J., & Baldwin, D. M. (1999). A process evaluation of the Forever Free Substance Abuse Treatment Program. Final report to the National Institute of Justice. Los Angeles: UCLA Drug Abuse Research Center.

Outcomes

Outcome 1: Drug use	
Description of Measures	Drug use was measured using structured interviews. Interviewers asked respondents to report frequency of drug use over the past year and during the past 30 days. Respondents were asked about 13 categories of drugs as well as drugs not specified in the categories.
Key Findings	In a study of outcomes for 180 women 1 year after their release from prison, 8% of Forever Free participants reported drug use in the past 30 days, compared with 32% of the comparison group ($p = .001$). A total of 50.5% of Forever Free participants reported any drug use in the past year, compared with 76.5% of comparison group participants ($p = .001$). In a study of outcomes for 64 women 1 year after their release from prison, a lower percentage of women who had participated in Forever Free and residential aftercare reported any heroin use in the past year (5.3%) than those who had not received aftercare (21.7%) and those in the no-treatment comparison group (40.9%). A total of 10.5% of Forever Free plus residential aftercare clients reported past-year amphetamine use, compared with 8.7% of those who did not participate in aftercare and 22.7% of the no-treatment comparison group. A total of 21.0% of Forever Free plus residential aftercare clients reported using cocaine or crack in the past year, compared with 69.5% of those who did not participate in residential care and 50.0% of the no-treatment comparison group.
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 2: Parole outcomes	
Description of Measures	Parole outcome data were collected using a structured interview. "Discharged/active with no return" was considered success. "Discharged/active returned to custody" and "in prison" were considered failures. In one study, reincarceration data were obtained from the Offender-Based Information System (OBIS).
Key Findings	In one study, 68.4% of Forever Free graduates who entered residential treatment had not returned

	to custody 1 year after release on parole; 52.2% of Forever Free graduates who did not enter residential treatment had not returned to custody, while only 27.2% of women in a no-treatment comparison group had not been returned to custody ($p < .05$). In a second study, 49.5% of Forever Free graduates compared with 74.7% of a no-treatment comparison group reported being arrested in the year following release from prison ($p = .001$).
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

Outcome 3: Employment after incarceration	
Description of Measures	Postincarceration employment was assessed with structured interviews. Participants were asked if they were employed, how many hours they worked per week, and the amount of their weekly take-home pay.
Key Findings	In a study of outcomes among 180 women 1 year after release from prison, 65.3% of Forever Free participants, compared with 44.7% of comparison group participants, were employed. The groups were equivalent in hours worked per week and weekly take-home pay.
Studies Measuring Outcome	Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race / Ethnicity
Study 1	26-55 (Adult)	100% Female	38.6% White 37% Black or African American 22.8% Hispanic or Latino 1.6% Race/ethnicity unspecified
Study 2	26-55 (Adult)	100% Female	34.6% Black or African American 33.6% White 22% Hispanic or Latino 9.8% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Drug use	2.8	3.1	2.8	3.3	2.3	3.5	**2.9**
2: Parole outcomes	3.1	3.1	2.8	3.3	2.8	4.0	**3.2**
3: Employment after incarceration	3.0	2.5	2.5	3.0	2.5	3.5	**2.8**

Study Strengths

The interview tools used in both studies were developed from other instruments with established reliability and validity. The researchers demonstrated effort to match comparison groups. Data analysis was appropriate.

Study Weaknesses

The sample sizes were small, allowing limited comparisons.

Readiness for Dissemination

Review Date: December 2006

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Center for Substance Abuse Treatment. (2006). Therapeutic community curriculum: Participant's manual (DHHS Publication No. [SMA] 06-4122). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2006). Therapeutic community curriculum: Trainer's manual (DHHS Publication No. [SMA] 06-4121). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Covington, S. (1999). A woman's journal (participant workbook from Helping women recover: A program for treating substance abuse, criminal justice edition). San Francisco: Jossey-Bass.

Covington, S. (2000). A woman's way through the twelve steps. Center City, MN: Hazelden.

Covington, S. (2002). Women in recovery: Understanding addiction. Carson City, NV: The Change Companies.

Covington, S. (2003). A healing journey: A workbook for women (participant workbook from Beyond trauma: A healing journey for women). Center City, MN: Hazelden.

De Leon, G., Melnick, G., & Center for Therapeutic Community Research. (1993). Therapeutic community Survey of Essential Elements Questionnaire (SEEQ)--Short form. New York: Community Studies Institute.

Fry, R., Johnson, S., Melendez, P., & Morgan, R. (1998). A parent's guide to changing destructive adolescent behavior. Ontario, CA: Parent Project.

Gordon Graham and Company, Inc. (1993). A framework for recovery. Bellevue, WA: Authors.

Gordon Graham and Company, Inc. (1998). A framework for breaking barriers. Bellevue, WA: Authors.

Gorski, T. (1997). The GORSKI-CENAPS model: An overview. Homewood, IL: Author.

Gorski, T., & Trundy, A. (2000). Relapse prevention counseling workbook: Practical exercises for managing high-risk situations. Homewood, IL: Terence T. Gorski.

Handouts:

- AWARE Questionnaire--Revised
- Client Satisfaction Survey
- Client Satisfaction Survey Procedure
- Client Satisfaction Survey Report
- Covington, S. (2005). Helping women recover: Creating gender-responsive services [PowerPoint handout].
- Group Schedule
- NREPP Overview of Forever Free Substance Abuse Program
- NREPP Overview: Training and Support Resources
- PowerPoint slide presentations from trainings and workshops
- Training and workshop overviews
- Treatment Components
- Workshop Schedule

Hermes, S. (1998). Assertiveness: Practical skills for positive communication. Center City, MN: Hazelden Foundation.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
1.3	0.5	0.5	**0.8**

Dissemination Strengths

The program uses best-practice materials from a variety of expert resources targeted to this specific population. Some training materials are provided for topic areas relevant to the intervention. A client satisfaction survey and a standardized therapeutic community fidelity measure are provided to support quality assurance.

Dissemination Weaknesses

The program materials are specific to one implementation site and may not be easily adapted or transferred to other implementation sites. The relationship between the submitted program materials is unclear. While implementation, program goals, and recommendations for staffing are addressed in some of the materials, the guidance across these materials is inconsistent. No support resources specific to the program and its implementation are provided. The connection between the quality assurance measures provided and the program model is unclear. Materials state that one implementation site was engaged in external quality reviews, but no standards or protocols for evaluation or quality assessment are provided.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Implementation materials, training, technical assistance/consultation, and quality assurance materials	Contact the developer	Contact the developer

Additional Information

Forever Free was designed as an integrated system of services including multiple interventions. The cost of the program is $17 per day per participant. Most women stay in treatment between 3 and 6 months, yielding a total per-client cost of $1,500 to $3,000.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

* Hall, E. A., Prendergast, M. L., Wellisch, J., Patten, M., & Cao, Y. (2004). Treating drug-abusing women prisoners: An outcomes evaluation of the Forever Free program. Prison Journal, 76, 81-105.

Jarman, E. (1993). An evaluation of program effectiveness for the Forever Free Substance Abuse Program at the California Institution for Women, Frontera, California. Sacramento: California Department of Corrections, Office of Substance Abuse Programs.

* Prendergast, M. L., Wellisch, J., & Wong, M. M. (1996). Residential treatment for women parolees following prison-based drug treatment: Treatment experiences, needs and services, outcomes. Prison Journal, 76, 253-274.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Friends Care

Friends Care is a stand-alone aftercare program for probationers and parolees exiting mandated outpatient substance abuse treatment. The aftercare program is designed to maintain and extend the gains of court-ordered outpatient treatment by helping clients develop and strengthen supports for drug-free living in the community. Program goals include reduced drug use and criminal activity. Friends Care offers individual counseling to explore and resolve issues in maintaining a drug-free and productive life and to support efforts to continue drug-free functioning; case management to assist in obtaining needed services; skills building in job seeking and appropriate workplace demeanor; family relationship strengthening; education on HIV prevention; crisis intervention; and a peer support group. The program provides services for up to 6 months following discharge from an outpatient facility.

Descriptive Information

Areas of Interest	Substance abuse treatment
Outcomes	**Review Date: January 2008** 1: Opiate and/or cocaine use 2: Use of any illicit drug 3: Criminal activity
Outcome Categories	Crime/delinquency Drugs
Ages	18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Race/ethnicity unspecified
Settings	Correctional Other community settings
Geographic Locations	Urban
Implementation History	Friends Care was originally implemented and evaluated between 1997 and 2001 in Baltimore, Maryland. Three stand-alone aftercare facilities were established to serve probationer and parolee clients following discharge from six community outpatient treatment programs. The program served approximately 130 clients.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: No
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: January 2008

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Brown, B. S., O'Grady, K., Battjes, R. J., & Farrell, E. V. (2004). Factors associated with treatment outcomes in an aftercare population. American Journal on Addictions, 13(5), 447-460.

Brown, B. S., O'Grady, K. E., Battjes, R. J., Farrell, E. V., Smith, N. P., & Nurco, D. N. (2001). Effectiveness of a stand-alone aftercare program for drug-involved offenders. Journal of Substance Abuse Treatment, 21(4), 185-192.

Outcomes

Outcome 1: Opiate and/or cocaine use	
Description of Measures	Data on opiate and cocaine use were collected using the Texas Christian University intake and follow-up form. Respondents were asked to report their cocaine, opiate, and opiate and/or cocaine use during the past 30 days and 6 months using a 9-point scale ranging from 0 (never/not used) to 8 (about 4 or more times per day). Responses were aggregated to create measures of "any use" or "weekly or more use." Opiate use was defined as the use of heroin, heroin and cocaine mixed together, street methadone, or other opiates (i.e., opium, morphine, Demerol, Darvon). Cocaine use was defined as the use of crack/freebase, cocaine, or heroin and cocaine mixed together. Opiate and/or cocaine use was operationalized as the use of any opiate or cocaine-derived drug listed above.
Key Findings	At the 6-month follow-up, the percentage of clients reporting using opiates and opiates and/or cocaine at least weekly in the past 6 months was significantly smaller in the aftercare group than in the control group (3.2% vs. 11.8%, $p < .05$, and 4.3% vs. 17.6%, $p < .01$, respectively). The percentage of clients reporting using cocaine at least weekly also was smaller in the aftercare group than in the control group, but this difference did not reach statistical significance. After statistically controlling for demographic characteristics, mental health status, and community involvement, participation in aftercare services was shown to account for a significant reduction in any opiate and cocaine use during the same 6-month follow-up period. Specifically, compared with clients in the control condition, clients assigned to the aftercare condition were nearly one-fourth as likely to report using opiates one or more times ($p < .01$) and one-third as likely to report using cocaine one or more times ($p < .05$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 2: Use of any illicit drug	
Description of Measures	Data on illicit drug use were collected using the Texas Christian University intake and follow-up form. Respondents were asked to report their illicit drug use during the past 30 days and 6 months using a 9-point scale ranging from 0 (never/not used) to 8 (about 4 or more times per day). Responses were aggregated to create measures of "any use" or "weekly or more use."
Key Findings	At the 6-month follow-up, the percentage of clients reporting using any illicit drugs at least weekly in the past 6 months was significantly smaller in the aftercare group than in the control group (5.3% vs. 17.6%, $p < .05$). After statistically controlling for demographic characteristics, mental health status, and community involvement, participation in aftercare services was shown to account for a significant reduction in illicit drug use during the same 6-month follow-up period. Specifically, compared with clients in the control condition, clients in the aftercare condition were nearly one-third as likely to report using any illicit drug one or more times ($p < .01$) and one-fifth as likely to report using any illicit drug weekly or more often ($p < .01$).

Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Outcome 3: Criminal activity	
Description of Measures	Data on criminal activity were collected using the Texas Christian University intake and follow-up form. Respondents were asked to report their criminal activities during the past 30 days and 6 months. Specific measures included the number of days any illegal activity other than drug use was committed and the proportion of income derived from illegal activity.
Key Findings	At the 6-month follow-up, the percentage of clients reporting committing a crime in the past 30 days was significantly smaller in the aftercare group than in the control group (8.5% vs. 19.6%, $p < .05$). During the same 30-day period, clients in the aftercare condition also reported fewer days of criminal activity than those in the control condition (0.2 vs. 2.4 days, $p < .01$) and a smaller proportion of their income obtained from illegal activity ($p < .01$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult)	74.6% Male 25.4% Female	95.8% Black or African American 4.2% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Opiate and/or cocaine use	3.4	2.9	2.8	3.3	2.3	3.0	**2.9**
2: Use of any illicit drug	3.4	2.9	2.5	3.0	2.3	2.5	**2.8**
3: Criminal activity	2.5	2.2	3.0	3.0	2.3	2.8	**2.6**

Study Strengths

An experimental design was used to compare offenders receiving aftercare with those receiving services as usual. The researchers used random assignment and added nonrandomly assigned subjects only after the equality of groups was established. Multiple outcome measures were used; self-reported drug use measures were partially validated by urinalysis for the 6-month follow-up (i.e., 78% of participants reporting themselves as not using drugs in the past 30 days provided drug-free urine specimens). A manualized treatment protocol was employed, and training and oversight were provided. The researchers obtained excellent follow-up rates at 6 and 12 months. The sample size was adequate.

Study Weaknesses

Probationers and parolees living in the three catchment areas in which aftercare facilities were located were purposefully assigned to the intervention group, which weakened confidence in the study findings. The low initial participation rate in the study (54%) raised questions about other potential confounding variables, such as participant motivation, that could account for the findings. Limited information was documented on services outside the program that study participants received, reducing the ability to link outcomes to the program intervention. Underreporting of drug use was not accounted for in the analysis of drug outcomes.

Readiness for Dissemination

Review Date: January 2008

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Brown, B. S., Farrell, E., & Voskuhl, T. C. (1999). Manual for the Friends Care program: A program of aftercare services for drug treatment court clients.

Friends Care program instructions for completion of community contact form

National Institute on Drug Abuse. (1985). Leader's manual: Job seekers' workshop (DHHS Publication No. ADM 85-1424). Washington, DC: U.S. Government Printing Office.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
2.0	1.3	1.3	**1.5**

Dissemination Strengths

The program manual provides a structured service delivery approach and exercises to help implementers practice the concepts being taught. The manual also provides guidance for connecting with other community support services, working with families, and complying with requirements of the legal system. Training is available through the developer upon request. Service reports and program forms are provided to support quality assurance.

Dissemination Weaknesses

Some concepts and terminology in the implementation materials are outdated. No guidance is provided for organizational implementation. No formal training curriculum is available. No guidance is provided for monitoring program outcomes.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Program manual (includes quality assurance tools)	Free	Yes
3-week, on-site training	Free	Yes
Consultation by phone or email	Free	No

Additional Information

Implementation requires a stand-alone facility that is easily accessible to the community and personnel to deliver the program.

Replications

No replications were identified by the developer.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Helping Women Recover and Beyond Trauma

Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatment programs that, when combined, serve women in criminal justice or correctional settings who have substance use disorders and are likely to have co-occurring trauma histories (i.e., sexual or physical abuse). The two programs can be delivered conjointly as one intervention (as in the case of the research reviewed for this summary) or separately as independent, stand-alone treatments. The goals of the intervention for women in a criminal justice or correctional setting are to reduce substance use, encourage enrollment in voluntary aftercare treatment upon parole, and reduce the probability of reincarceration following parole. The trauma-informed treatment sessions are delivered by female counseling staff (who may be assisted by peer mentors, typically women serving life sentences) to groups of 8-12 female inmates, in a nonconfrontational and nonhierarchical manner. The counselors use a strengths-based approach with a focus on personal safety to help clients develop effective coping skills, build healthy relationships that foster growth, and develop a strong, positive interpersonal support network. Helping Women Recover and Beyond Trauma sessions use cognitive behavioral skills training, mindfulness meditation, experiential therapies (e.g., guided imagery, visualization, art therapy, movement), psychoeducation, and relational techniques to help women understand the different forms of trauma, typical reactions to abuse, and how a history of victimization interacts with substance use to negatively impact lives. The intervention is delivered through 1.5-hour sessions that occur once or twice each week. The Helping Women Recover program consists of 17 sessions organized around 4 domains: (1) Self, (2) Relationship/Support Systems, (3) Sexuality, and (4) Spirituality. The Beyond Trauma program consists of 11 sessions organized around 3 domains: (1) Violence, Abuse, and Trauma; (2) Impact of Trauma; and (3) Healing From Trauma. Although the intervention in the research reviewed by NREPP was designed for women in a criminal justice or correctional setting, a community version of the intervention also is available. The community version has been delivered in residential and outpatient substance abuse treatment settings, mental health clinics, and domestic violence shelters.

Descriptive Information

Areas of Interest	Substance abuse treatment Co-occurring disorders
Outcomes	**Review Date: June 2010** 1: Substance use 2: Aftercare retention and completion 3: Reincarceration
Outcome Categories	Alcohol Crime/delinquency Drugs Treatment/recovery
Ages	26-55 (Adult)
Genders	Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Correctional
Geographic Locations	No geographic locations were identified by the developer.
Implementation History	Helping Women Recover has been implemented in more than 1,100 criminal justice programs with over 29,000 women and in more than 2,200 community-based programs with over 24,000 women. Beyond Trauma has been implemented in more than 1,500 criminal justice and community sites with 30,000 women. In one women's prison in California, over 500 women have participated in the program. The Helping Women Recover

	and Beyond Trauma intervention also has been implemented in Canada (New Westminster and Vancouver, British Columbia; Winnipeg, Manitoba; Halifax and Yarmouth, Nova Scotia; and Ottawa, Ontario) and in Ireland (Cork, Dublin, and Galway). The Beyond Trauma curriculum has been taught in graduate schools of social work in Berlin and Bremen, Germany.
NIH Funding / CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	The Beyond Trauma curriculum has been translated into German.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: June 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Messina, N., Grella, C. E., Cartier, J., & Torres, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. Journal of Substance Abuse Treatment, 38(2), 97-107.

Supplementary Materials

Calhoun, S., Messina, N., Cartier, J., & Torres, S. (2010). Implementing gender-responsive treatment for women in prison: Client and staff perspectives. Federal Probation, 74(3). Retrieved from http://www.uscourts.gov/uscourts/FederalCourts/PPS/Fedprob/2010-12/implementing.html

Covington, S. S. (2008). Women and addiction: A trauma-informed approach. Journal of Psychoactive Drugs, SARC Suppl. 5, 377-385.

Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. Journal of Psychoactive Drugs, SARC Suppl. 5, 387-398.

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., et al. (1992). The fifth edition of the Addiction Severity Index. Journal of Substance Abuse Treatment, 9(3), 199-213.

Outcomes

Outcome 1: Substance use	
Description of Measures	Substance use was measured with the drug use composite score from the Addiction Severity Index (ASI) Lite. The ASI Lite is a shortened version of the ASI, a semistructured interview instrument that evaluates the severity of psychosocial problems across seven life domains: medical, employment, alcohol, drugs, legal, family/social, and psychiatric. Composite scores of 0 to 1 are generated for each domain, with higher scores reflecting greater problem severity. Assessments occurred at baseline (entry into a prison-based therapeutic community [TC]) and at two postparole follow-up points: "6 months" (which occurred, on average, at 8.8 and 9.8 months after parole for the intervention and comparison groups, respectively) and "12 months" (which occurred, on average, at 15.5 and 13.9 months after parole for the intervention and comparison groups, respectively).
Key Findings	In a randomized clinical trial, female inmates who had a substance use history and were scheduled for parole within 24 months were randomly assigned to one of two 6-month prison-based TCs: an intervention group receiving Helping Women Recover and Beyond Trauma or a comparison group receiving standard treatment. From baseline to the 12-month postparole follow-up, women in the intervention group had a larger decrease in drug use composite scores than their counterparts in the comparison group, after controlling for ethnicity, marital status, and employment ($p < .03$).

Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.3 (0.0-4.0 scale)

Outcome 2: Aftercare retention and completion	
Description of Measures	Aftercare retention and completion were measured as the total number of months in the first episode of community residential aftercare treatment following parole and as the successful completion of this treatment, respectively. Information was obtained from archival data (aftercare treatment admission and discharge records) available in the California Department of Corrections and Rehabilitation's Offender Substance Abuse Tracking System and from treatment providers. Records were obtained at the end of the study for the 12-month period following parole.
Key Findings	In a randomized clinical trial, female inmates who had a substance use history and were scheduled for parole within 24 months were randomly assigned to one of two 6-month prison-based TCs: an intervention group receiving Helping Women Recover and Beyond Trauma or a comparison group receiving standard treatment. Retention in the first episode of residential aftercare treatment following parole was longer for women in the intervention group than it was for women in the comparison group (2.6 vs. 1.8 months; $p < .05$). Additionally, women in the intervention group were more than 4 times as likely as women in the comparison group were to successfully complete this aftercare treatment episode following parole (odds ratio = 4.60; $p < .05$). These differences in retention and completion were associated with medium effect sizes (Cohen's $d = 0.58$ and 0.67, respectively).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.5 (0.0-4.0 scale)

Outcome 3: Reincarceration	
Description of Measures	Reincarceration was measured using archival data available in the California Department of Corrections and Rehabilitation's Offender Based Information System. Records were obtained at the end of the study for the 12-month period following parole.
Key Findings	In a randomized clinical trial, female inmates who had a substance use history and were scheduled for parole within 24 months were randomly assigned to one of two 6-month prison-based TCs: an intervention group receiving Helping Women Recover and Beyond Trauma or a comparison group receiving standard treatment. A smaller percentage of intervention group than comparison group women were reincarcerated (31% vs. 45%; $p < .05$) during the 12 months following parole. During this time, intervention group women were 67% less likely than comparison group women were to be reincarcerated, after controlling for ethnicity, marital status, and living situation (odds ratio = 0.33; $p < .05$). This group difference was associated with a small effect size (Cohen's $d = 0.28$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.5 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	100% Female	48% White 26% Hispanic or Latino 17% Black or African American 9% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Substance use	3.2	2.5	1.4	2.2	2.2	2.5	**2.3**
2: Aftercare retention and completion	2.3	2.8	1.4	2.2	2.7	3.5	**2.5**
3: Reincarceration	2.9	2.9	1.4	2.2	2.7	3.0	**2.5**

Study Strengths

The ASI Lite drug use composite score, when calculated for the past 30 days, has good reliability. Treatment provider logs and administrative databases are valid measures of documented service utilization, and some client reports were cross-checked with this documentation. Similarly, administrative databases of the State's Department of Corrections and Rehabilitation are valid measures of arrests and incarcerations. The treatment was manual driven, and assessments were conducted by research assistants, not the interventionists, which minimized therapist bias. The researchers carried out random assignment successfully in a prison environment and prevented cross-contamination between the intervention and comparison groups by having completely separate TC treatment environments, which controlled for many potential confounding variables.

Study Weaknesses

Baseline ASI Lite data were collected retrospectively for 30 days and 6 months before incarceration with no clear reliability and validity support. Six-month postparole data were collected for a follow-up period during which access to drugs was controlled for about half of the study participants, who typically entered a residential aftercare treatment service immediately after parole. Although the interventionists were occasionally observed by the developer of the intervention and lead researcher, they did not receive systematized oversight with coaching or feedback. In addition, the researchers did not measure intervention fidelity or therapy exposure, nor did they rate the prison TC core processes that were intended to be altered through the implementation of the trauma-informed model. The first aftercare service, which was usually residential and the longest treatment episode, imposed a controlled environment on clients and was more proximal to the 6- and 12-month follow-up periods; thus, it is possible that the substance use and reincarceration outcomes can be attributed to retention in aftercare services rather than the preceding in-prison intervention. The follow-up rate at 12 months following parole was slightly low at 76%, and both the 6- and 12-month follow-up assessments were conducted during large time windows. The within-subjects repeated measures analysis of the ASI Lite drug use composite score did not include clients with missing data and did not control for time in a controlled setting at each follow-up.

Readiness for Dissemination

Review Date: June 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Beyond Trauma materials:

- Assessment of Skills--Beyond Trauma
- Beyond Trauma: A Healing Journey for Women--Bibliography
- Beyond Trauma: A Healing Journey for Women--Implementation Guidelines
- Covington, S. S. (2003). A Healing Journey: A workbook for women. Center City, MN: Hazelden.
- Covington, S. S. (2003). Beyond Trauma: A Healing Journey for Women facilitator's guide. Center City, MN: Hazelden.
- Covington, S. S. (2010, March). Beyond Trauma: A Healing Journey for Women [PowerPoint slides].
- Hazelden (Producer). (2003). Beyond Trauma: A Healing Journey for Women client video [DVD]. Center City, MN: Hazelden.
- Hazelden (Producer). (2003). Beyond Trauma: A Healing Journey for Women facilitator video 1 [DVD]. Center City, MN: Hazelden.
- Hazelden (Producer). (2003). Beyond Trauma: A Healing Journey for Women facilitator video 2 [DVD]. Center City, MN: Hazelden.

Helping Women Recover materials:

- Assessment of Skills--Helping Women Recover
- Covington, S. S. (2008). A woman's journal. San Francisco: Jossey-Bass.
- Covington, S. S. (2008). A woman's journal--Special edition for the criminal justice system. San Francisco: Jossey-Bass.
- Covington, S. S. (2008). Helping Women Recover: A Program for Treating Addiction. San Francisco: Jossey-Bass.
- Covington, S. S. (2008). Helping Women Recover: A Program for Treating Substance Abuse--Special edition for the criminal justice system. San Francisco: Jossey-Bass.
- Covington, S. S. (2010, March). Helping Women Recover: A trauma-informed approach [PowerPoint slides].
- Helping Women Recover--Implementation Guidelines

Materials for both programs:

- Developer's Web site, http://www.stephaniecovington.com
- Gender-Responsive Program Assessment
- Gender-Responsive Program Assessment (Abbreviated)
- Helping Women Recover and/or Beyond Trauma--Implementation Form
- Program Web site, http://www.centerforgenderandjustice.org
- Services for Women and Girls Trauma-Informed Inventory

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	3.5	2.3	**3.3**

Dissemination Strengths

Program materials are well written, logically sequenced, comprehensive, and straightforward. They include useful tips for effective group facilitation, and they anticipate and answer questions that clinicians and program supervisors may have in regard to the intervention. The program developer provides on-site training that is tailored to the needs of the implementing organization, along with phone- and email-based support during implementation. Several tools are provided to support quality assurance.

Dissemination Weaknesses

No training specifically designed for program supervisors is available to help them provide clinicians with ongoing guidance, ensure clinicians' continued competence, and support those at risk for secondary trauma. No guidance is provided for using quality assurance tools or for using the data derived from these tools to determine the program's impact.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Helping Women Recover facilitator's guide (includes one participant workbook)	$195 each	Yes
Helping Women Recover participant workbook	$26.95 per participant	Yes
Beyond Trauma facilitator's guide	$89.95 each	Yes
Beyond Trauma participant workbook	$9.95 per participant ($79 for 10)	Yes
Beyond Trauma facilitator DVDs (two)	$225 per set	No

Beyond Trauma client DVD	$99 each	No
2-day, on-site Helping Women Recover facilitator training	$4,000-$10,000 depending on location, trainer, and site needs	No
2-day Helping Women Recover facilitator training, located at various sites across the United States	$100-$200 per person depending on location	No
Annual 3-day Helping Women Recover facilitator training in Minneapolis, MN	$159 per person	No
2-day, on-site Beyond Trauma facilitator training	$4,000-$10,000 depending on location, trainer, and site needs	No
2-day Beyond Trauma facilitator training, located at various sites across the United States	$100-$200 per person depending on location	No
Annual 3-day Beyond Trauma facilitator training in Minneapolis, MN	$159 per person	No
On-site, email, and phone consultation	Varies depending on site needs	No
Quality assurance tools	Free	No

Additional Information

Discounts are available for program materials purchased either in large quantities or as a set.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Bond, K., Messina, N., & Calhoun, S. (2010). Enhancing substance abuse treatment and HIV prevention for women offenders: Final report (Report to the National Institute on Drug Abuse, Grant No. 1 R01 DA022149-01). Unpublished manuscript.

Contact Information

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.centerforgenderandjustice.org**
- **http://www.stephaniecovington.com**

Interactive Journaling

Interactive Journaling is a goal-directed, client-centered model that aims to reduce substance abuse and substance-related behaviors, such as recidivism, by guiding adults and youth with substance use disorders through a process of written self-reflection. The model is based on structured and expressive writing techniques, principles of motivational interviewing, cognitive-behavioral interventions, and the integration of the transtheoretical model of behavior change. The approach helps participants modify their behavior as they progress through the stages of change that underlie the transtheoretical model: (1) precontemplation (not intending to begin the change in behavior in the next 6 months), (2) contemplation (intending to begin the change in behavior in the next 6 months), (3) preparation (intending to begin the change in behavior in the next 30 days), (4) action (practicing the behavior for less than 6 months), and (5) maintenance (practicing the behavior for at least 6 months).

The focus of the Interactive Journaling model is the participant journal, which includes worksheets with nonconfrontational questions intended to help participants think and then write about their substance use problem and its association with their current negative life situation, which may include incarceration or arrest for driving under the influence (DUI). Using the journal, participants explore and resolve a variety of topics, including ambivalence toward their substance use, recognition that they have a substance use problem, the connection between substance use and their current situation, health and other consequences of substance use, and irresponsible behavior while under the influence of alcohol and/or drugs. Questions also guide participants in considering their motivations for change, exploring behavior change options, and developing a plan with target behavior-related goals and a timeline for achieving these goals.

The journals used in Interactive Journaling vary in length on the basis of the target population, the setting, and the type of delivery. Interactive Journaling can be delivered as a self-guided program, or it can be facilitated through one-on-one sessions or in a group format; it can also be used as part of a primary substance abuse treatment or prevention program.

Two studies were reviewed for this summary. One study included a 24-page journal titled "Changing Course," which was delivered as a self-guided program for reducing recidivism among male inmates who had substance use dependence, were incarcerated at a local jail, and had at least one other arrest in the previous 12 months. Another study included a 64-page journal, which was delivered as the basis of a 12-hour, facilitated course curriculum for reducing recidivism among first-time DUI offenders.

Descriptive Information

Areas of Interest	Substance abuse prevention Substance abuse treatment Co-occurring disorders
Outcomes	**Review Date: February 2013** 1: Recidivism
Outcome Categories	Crime/delinquency
Ages	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)
Genders	Male Female
Races/Ethnicities	American Indian or Alaska Native Black or African American White Race/ethnicity unspecified
Settings	Outpatient Correctional

	Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier Tribal
Implementation History	In 1989, The Change Companies (originally Serenity Support Services), in partnership with professional staffs at 25 hospital-based addiction and mental health programs, created and delivered the first Interactive Journaling resource. Annually, over 3,500 sites use Interactive Journaling curricula in their behavior change programming. To date, Interactive Journaling has served approximately 20 million individuals in the areas of treatment, corrections, impaired driving, prevention education, and health care, as well as military personnel in the U.S. Army, Navy, Air Force, and Marines. The program has been implemented in all 50 States, Puerto Rico, and the U.S. Virgin Islands and in Australia, the Bahamas, Bermuda, Canada, New Zealand, and Thailand.
NIH Funding / CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Interactive Journaling has been adapted for use with the following populations: • For incarcerated offenders--BRAVE Program, Challenge Program, Breaking the Cycle: Nonresidential Drug Abuse Program, Choice and Change and Freedom From Drugs, The Corrective Actions Journaling System, and Managing Co-Occurring Disorders: An Integrated Approach Series • For offenders at prison release--Getting It Right and The Courage to Change • For incarcerated women offenders with substance dependence--Residential Drug Abuse Program • For short-term incarcerated offenders--Changing Course • For youth offenders--Forward Thinking Program • For youth dealing with alcohol and other drug-related violations--Alternatives Interactive Journaling • For gang populations--The Choice Is Yours • For alcohol-impaired drivers--24 adaptations of Interactive Journaling • For women--Women in Recovery and Trauma in Life Interactive Journaling • For teenage girls--Voices, a program to strengthen sense of self and build skills for healthy development (adapted in collaboration with Stephanie Covington) • For youth--Keep It Direct and Simple (KIDS), Helping Children Thrive, and In My House • For students entering college--CHOICES, an alcohol abuse prevention program (adapted in collaboration with Alan Marlatt and George Parks) • For faith-based populations--Salvation Army Adult Rehabilitation Centers Interactive Journaling Series, ARC Interactive Journaling: French-Canadian Series, Partners in Prevention: Preparing Jewish Youth for a Drug-Free Journey, and Live Free • For Native Americans of the Oglala Lakota Nation with substance use problems--Strengthening the Spirit • For Canada's First Nation populations--The Courage to Change Interactive Journaling Program-Saskatchewan Series • For Haitian-Creole populations--The Drug, Alcohol, Traffic Education (DATE) Program (translated into Haitian-Creole and Spanish) • For Hispanic populations--My Personal Journal-Adult Treatment (Mi Diario Personal), Choice and Change-Drug Education (Decisiones y Cambio), Women in Recovery (Mujeres en Recuperacion), Transition Skills (Habilidades para la Transcion), and numerous alcohol-impaired driver Interactive Journaling curricula that have been translated into Spanish and culturally modified for use with these populations • For populations with co-occurring disorders--Self-Management: A Guide to Your Feelings, Motivations, and Positive Mental Health-Addiction Treatment Edition (adapted in collaboration with William Miller and David Mee-Lee) • For those who want to quit smoking--"I Don't Smoke!" Interactive Journaling • For compulsive gamblers--A 12-Step Guide for Compulsive Gamblers • For individuals in residential or community-based programs--My Personal Health Journal
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Indicated

Quality of Research

Review Date: February 2013

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Proctor, S. L., Hoffmann, N. G., & Allison, S. (2012). The effectiveness of Interactive Journaling in reducing recidivism among substance-dependent jail inmates. International Journal of Offender Therapy and Comparative Criminology, 56(2), 317-332.

Study 2

Loudenburg, R. (2008). South Dakota Public Safety DUI Program: Four year evaluation report. Data period January 2004 through December 2007 (Prepared for the Office of Highway Safety, South Dakota Department of Public Safety). Salem, SD: Mountain Plains Evaluation.

Supplementary Materials

Campbell, T. C., Hoffmann, N. G., Hoffmann, T. D., & Gillaspy, J. A. (2005). UNCOPE: A screen for substance dependence among state prison inmates. Prison Journal, 85(1), 7-17.

Hoffmann, N. G. (2000). CAAPE (Comprehensive Addictions and Psychological Evaluation) manual. Carson City, NV: The Change Companies.

Hoffmann, N. G. (2000). Comprehensive Addictions and Psychological Evaluation (CAAPE) summary data and survey items. Carson City, NV: The Change Companies.

Hoffmann, N. G., Hunt, D. E., Rhodes, W. M., & Riley, K. J. (2003). UNCOPE: A brief substance dependence screen for use with arrestees. Journal of Drug Issues, 33(1), 29-44.

Miller, W. R. (2013). Interactive Journaling as a clinical tool: Description and research. Unpublished manuscript.

Proctor, S. L., Corwin, C. J., Hoffmann, N. G., & Allison, S. (2009). A tool to engage jail inmates: A trademarked journaling process shows promise in giving offenders insight on their substance use. Addiction Professional, 7(1), 22-25.

Outcomes

Outcome 1: Recidivism	
Description of Measures	In one study, recidivism was defined as the rearrest and booking of a study inmate at the Buncombe County Detention Facility (BCDF) in the 12 months after study entry. Data were obtained from the management information system (MIS) of the BCDF, which is the only jail facility available for the local city police department and the county sheriff's office. These data were used to calculate the percentage of study participants who were rearrested and booked at the BCDF. In another study, recidivism was defined as a rearrest for a DUI offense in the study's 4-year follow-up period. Data were obtained from South Dakota DUI-related arrest records extracted from the Unified Judicial System database for the 2004-2007 timeframe. These data were used to calculate (1) the percentage of study participants who were rearrested for a DUI offense and (2) the rate of recidivism, monitored through the use of a survival function that compared the length of time between first and subsequent DUI arrests for participants.
Key Findings	In a randomized clinical trial with male inmates incarcerated in a county jail facility, participants who were identified as being dependent on one or more substances (according to the Comprehensive Addictions and Psychological Evaluation Manual, which follows DSM-IV-TR diagnostic criteria) and whose current offense was related to substance involvement, with a minimum of one prior incarceration in the previous 12 months, were assigned to the intervention or comparison condition. Inmates in the intervention group received a 24-page interactive journal titled "Changing Course" from a research staff assistant, who provided a 10-minute introduction on the contents of the journal and the journaling process. Inmates in the comparison group received a government booklet on substance use disorders and criminal behavior, with information on substance use and related problems and a telephone number for a national hotline that they could call when released from jail if they were interested in treatment services. Rearrests for each study participant were tracked through the BCDF MIS for the 12-month period following study entry. In the 12 months after study entry, the percentage of participants rearrested and booked at the BCDF was lower for the intervention group than the comparison group (51% vs. 66%; $p < .05$). In a retrospective, quasi-experimental study, first-time DUI offenders (18 years and older) in two study conditions were matched and compared. Participants in the intervention group received the South Dakota Public Safety DUI Interactive Journaling course curriculum from 2004 through 2007. The curriculum consisted of a 64-page journal and was delivered through six 2-hour or four 3-hour classroom-type group sessions by 13 State alcohol/drug treatment agencies using the same

	structured facilitator guide. Participants received a journal at the first session, and during each session, they completed writing elements in the journal under the guidance of the course facilitator. Writing assignments were given between course sessions, and participants were encouraged to practice and discuss the curriculum content with a concerned friend, family member, and/or significant other outside of the sessions. Participants in the control group were first-time DUI offenders (with arrests in 2003) who had not received the Interactive Journaling course curriculum. Findings included the following, from 2004 through 2007: • Among all participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (13.5% vs. 18.5%; p < .001), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among male participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (15.1% vs. 20.3%; p < .001), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among female participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (10.4% vs. 15.2%; p < .001), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among 21- to 29-year-old participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (15.2% vs. 20.3%; p < .001), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among 30- to 39-year-old participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (10.9% vs. 17.3%; p < .001), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among 40- to 49-year-old participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (12.1% vs. 17.2%; p = .002), and the rate of recidivism was slower for the intervention group than the control group (p < .0001). • Among 50- to 59-year-old participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (7.3% vs. 12.2%; p = .013), and the rate of recidivism was slower for the intervention group than the control group (p = .0023). • Among 60- to 90-year-old participants, the percentage of those rearrested for DUI was lower for the intervention group than the control group (2.2% vs. 9.5%; p = .011); however, there was no significant difference between groups in regard to the rate of recidivism.
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	2.5 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	100% Male	73.2% White 23.5% Black or African American 3.3% Race/ethnicity unspecified
Study 2	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	68.8% Male 27.4% Female	85% White 8.3% American Indian or Alaska Native 6.6% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating

1: Recidivism	2.5	2.5	1.8	3.5	2.3	2.8	**2.5**

Study Strengths

Recidivism was calculated from arrest data entered into standardized databases regulated by the criminal justice system at a county level in one study and at a State level in another study, providing both a certain level of reliability (owing to the legal necessity of recording arrests accurately) and validity (owing to the total independence of the investigators). The accurate extraction of arrest data from databases by research assistants was independently verified, and there is construct validity for definitions of arrests on the basis of the criminal justice legal system. In a study with first-time DUI offenders, the investigators and alcohol/drug treatment agencies delivering the curriculum worked together to train instructors and document pre- and postintervention changes in knowledge and attitudes about substance use and driving with 1-year follow-up assessments. There were no missing arrest data for the immediate catchment area of either study owing to the record databases. One study used random assignment (i.e., a coin toss), which generally controlled for many potential confounding variables. One study used a sophisticated survival analysis to model the longitudinal recidivism data from participants in both study conditions.

Study Weaknesses

Neither study provided formal reliability or validity estimates for the arrest data in the database nor for the subsequent extraction of the arrest data. There was no formal measurement of intervention fidelity in either study. In one study, there was no information as to what was said during the research assistant's 10-minute talk with participants regarding the journal, no effort was made to determine whether participants actually wrote in their journals, and no feedback was provided to participants by a staff person. In another study, there was no tracking of whether participants wrote in their journals, and there was no tracking of the feedback participants received about what they wrote. Because it is not known how much participants (particularly those with reading or writing deficits) wrote in their journals, it is difficult to know how tightly coupled the actual journaling is to the recidivism outcome in either study. Additional confounding variables specific to study design cannot be ruled out in one study, which was a quasi-experimental retrospective review of database records limited to one State.

Readiness for Dissemination

Review Date: February 2013

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Sample implementation and training materials:

- Alaska Alcohol and Drug Information School:
  - The Change Companies & the State of Alaska. (2011). Alaska Alcohol and Drug Information School. Carson City, NV: The Change Companies.
  - The Change Companies & the State of Alaska. (2011). Instructor guide for Alaska Alcohol and Drug Information School. Carson City, NV: The Change Companies.

- CHOICES About Alcohol:
  - The Change Companies, Marlatt, A., & Parks, G. (2010). CHOICES About Alcohol: A brief alcohol abuse prevention program [Participant journal].
  - The Change Companies, Marlatt, A., & Parks, G. (2010). CHOICES: Facilitation summary: A brief alcohol abuse prevention program.
  - The Change Companies. (n.d.). CHOICES: A brief alcohol abuse prevention program: Course evaluation. Carson City, NV: Author.
  - The Change Companies. (n.d.). CHOICES: Pre/post-test. Carson City, NV: Author.

- Crow Nation:
  - The Change Companies. (2010). Facilitation training: Crow Nation: Adult & adolescent treatment: Interactive Journaling systems. Carson City, NV: Author.
  - The Change Companies. (2010). Implementation training: Crow Nation: Adult & adolescent treatment: Interactive Journaling systems. Carson City, NV: Author.
  - The Change Companies. (2011). Crow Nation training agenda. Carson City, NV: Author.
  - The Change Companies. (n.d.). Welcome: Crow Nation: Interactive Journaling implementation & facilitation training [PowerPoint slides]. Carson City, NV: Author.

- Managing Co-Occurring Disorders: An Integrated Approach:
  - The Change Companies. (2005). Managing Co-Occurring Disorders: An Integrated Approach: Orientation [Participant journal]. Carson City, NV: Author.
  - The Change Companies. (2005). Managing Co-Occurring Disorders: An Integrated Approach: Orientation: Facilitator guide. Carson City, NV: Author.

- Motivational-Educational-Experiential (MEE) Interactive Journaling System:
  - The Change Companies. (2008). Getting started [Participant journal]. Carson City, NV: Author.

- The Change Companies. (2008). Implementing the getting started journal: Facilitator guide. Carson City, NV: Author.
- The Change Companies. (2008). Recovery maintenance [Participant journal]. Carson City, NV: Author.
- The Change Companies. (2011). Chemical Addictions Program, Inc.: Facilitation training on Interactive Journaling. Carson City, NV: Author.
- The Change Companies. (2011). Chemical Addictions Program, Inc.: MEE Interactive Journaling System. Carson City, NV: Author.
- The Change Companies. (2011). Chemical Addictions Program, Inc.: MEE Interactive Journaling System: Trainer's manual. Carson City, NV: Author.
- The Change Companies. (n.d.). MEE Interactive Journaling system: Training resources [CD-ROM]. Carson City, NV: Author.
- The Change Companies. (n.d.). Telephone orientation: MEE Interactive Journal series. Carson City, NV: Author.

- New Mexico DWI Education Program:
  - The Change Companies. (2010). Booster training: New Mexico DWI Education Program: Department of Transportation Traffic Safety Bureau. Carson City, NV: Author.
  - The Change Companies. (2010). Welcome New Mexico Traffic Safety Bureau: Booster training [PowerPoint slides]. Carson City, NV: Author.

- Residential Drug Abuse Program:
  - The Change Companies. (2004). Residential Drug Abuse Program: Facilitator guide for orientation. Carson City, NV: Author.
  - The Change Companies. (2004). Residential Drug Abuse Program: Orientation [Participant journal]. Carson City, NV: Author.
  - The Change Companies. (2004). Residential Drug Abuse Program: Recovery maintenance [Participant journal]. Carson City, NV: Author.

- Responsible Decisions:
  - The Change Companies. (2009). Responsible Decisions: Impaired driving program [Participant journal]. Carson City, NV: Author.
  - The Change Companies. (2009). Responsible Decisions: Impaired driving program: Facilitator guide. Carson City, NV: Author.

- Self-Management: A Guide to Your Feelings, Motivations, and Positive Mental Health: Addiction Treatment Edition:
  - Miller, W. R., & Mee-Lee, D. (2010). Self-Management: A Guide to Your Feelings, Motivations, and Positive Mental Health (Addiction Treatment Edition). Carson City, NV: The Change Companies.
  - Miller, W. R., & Mee-Lee, D. (2010). Self-Management: A Guide to Your Feelings, Motivations, and Positive Mental Health (Addiction Treatment Edition): Facilitator guide. Carson City, NV: The Change Companies.

- South Dakota Public Safety DUI Program:
  - Cancer Prevention Research Center Transtheoretical Model: Detailed Overview of the Transtheoretical Model. Retrieved from http://www.uri.edu/research/cprc/TTM/detailedoverview.htm
  - Cognitive Behavior Therapy [Informational handout]
  - Lemus, F. D. (2006). Change is good. Paradigm, 2006(Winter), 8-10.
  - Lieb, S. (1991). Principles of adult learning. Vision, 1991(Fall).
  - Rollnick, S., & Miller, W. R. (2010). What is MI? Retrieved from http://motivationalinterview.net/clinical/whatismi.html
  - The Change Companies. (2008). Distant learning module: An introduction to Interactive Journaling [Training journal]. Carson City, NV: Author.
  - The Change Companies. (2009). Course evaluation: South Dakota Public Safety DUI Program. Carson City, NV: Author.
  - The Change Companies. (2009). Facilitator guide for the South Dakota Public Safety DUI Program. Carson City, NV: Author.
  - The Change Companies. (2009). Post-test: South Dakota Public Safety DUI Program. Carson City, NV: Author.
  - The Change Companies. (2009). Pre-test: South Dakota Public Safety DUI Program. Carson City, NV: Author.
  - The Change Companies. (2009). South Dakota: Pre-/post-test answer key. Carson City, NV: Author.
  - The Change Companies. (2009). South Dakota Public Safety DUI Program [Participant journal]. Carson City, NV: Author.
  - The Change Companies. (2009). South Dakota Public Safety DUI Program instructions. Carson City, NV: Author.
  - The Change Companies. (2011). Adult learning [Handout]. Carson City, NV: Author.
  - The Change Companies. (2011). Learning styles [Handout]. Carson City, NV: Author.
  - The Change Companies. (2011). Observation and feedback form. Carson City, NV: Author.
  - The Change Companies. (2011). Session design: South Dakota Public Safety DUI Program. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Booster training [Training workbook]. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Booster training lesson plan. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Implementation training [PowerPoint slides]. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Implementation training [Training workbook]. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Implementation training lesson plan. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Orientation training [PowerPoint slides]. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Orientation training [Training workbook]. Carson City, NV: Author.
  - The Change Companies. (2011). South Dakota Public Safety DUI Program: Orientation training lesson plan. Carson City, NV: Author.
  - The Change Companies. (2011). What do you think? [Training evaluation]. Carson City, NV: Author.
  - The Change Companies. (n.d.). South Dakota Public Safety DUI Program: Implementation training [PowerPoint slides]. Carson City, NV: Author.

- The Change Companies. (n.d.). South Dakota Public Safety DUI Program: Participant training journal. Carson City, NV: Author.
- The Change Companies. (n.d.). South Dakota Public Safety DUI Program: Training resources [CD-ROM]. Carson City, NV: Author.
- The Change Companies. (n.d.). South Dakota Public Safety DUI school: Training for trainers lesson plan. Carson City, NV: Author.
- The Change Companies. (n.d.). Telephone orientation: South Dakota Public Safety DUI Program. Carson City, NV: Author.

- Substance Abuse: The Courage To Change:
  - The Change Companies. (2008). Substance Abuse: The Courage To Change: Interactive Journaling system. Carson City, NV: Author.
  - The Change Companies. (2011). Advanced training: The Courage To Change: Interactive Journaling system. Carson City, NV: Author.
  - The Change Companies. (2011). Substance Abuse: The Courage To Change Interactive Journaling system: Facilitator guide. Carson City, NV: Author.
  - The Change Companies. (2011). The Courage To Change: Interactive Journaling system: Advanced training: US probation--District of Hawaii. Carson City, NV: Author.
  - The Change Companies. (2011). US probation, District of Hawaii: Advanced training agenda/lesson plan. Carson City, NV: Author.
  - The Change Companies. (n.d.). Assessment of participant: Substance abuse. Carson City, NV: Author.
  - The Change Companies. (n.d.). Participant evaluation of facilitator: The Courage To Change. Carson City, NV: Author.
  - The Change Companies. (n.d.). Supervisor/observer evaluation of facilitator: The Courage To Change. Carson City, NV: Author.
  - The Change Companies. (n.d.). The Courage To Change: Evaluation and assessment instructions. Carson City, NV: Author.

- Virginia Alcohol Safety Action Program (VASAP):
  - The Change Companies. (2011). The Commission on Virginia Alcohol Safety Action Program (VASAP): Orientation training on Interactive Journaling. Carson City, NV: Author.
  - The Change Companies. (2011). The Commission on Virginia Alcohol Safety Action Program (VASAP): The Change Companies welcomes VASAP instructors [PowerPoint slides]. Carson City, NV: Author.
  - The Change Companies. (2011). Virginia Alcohol Safety Action Program (VASAP) orientation training agenda. Carson City, NV: Author.
  - The Change Companies & the Commission on Virginia Alcohol Safety Action Program (VASAP). (2011). Education group workbook [Participant journal]. Carson City, NV: The Change Companies.

Non-program-specific training resources from the Change Companies:

- The Change Companies. (2008). Distance learning module: An introduction to Interactive Journaling. Carson City, NV: Author.
- The Change Companies. (2008). Looking at the consequences [Training handout]. Carson City, NV: Author.
- The Change Companies. (2008). Repairing damaged relationships [Training handout]. Carson City, NV: Author.
- The Change Companies. (2010). Interactive Journaling exercise [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Adult learning [Handout]. Carson City, NV: Author.
- The Change Companies. (2011). Decisional balance exercise [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Eliciting change talk (D.A.R.N.) [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Facilitation exercise #1: Responsive listening [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Helping people change: Engaging clients in collaborative treatment. Carson City, NV: Author.
- The Change Companies. (2011). Individual application [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Learning styles [Handout]. Carson City, NV: Author.
- The Change Companies. (2011). Readiness to change [Training handout]. Carson City, NV: Author.
- The Change Companies. (2011). Writing an introduction [Training handout]. Carson City, NV: Author.

Other implementation and training documents:

- Covington, S. (2004). Voices: A program of self-discovery and empowerment for girls. Carson City, NV: The Change Companies.
- The Change Companies. (1999). Strengthening the spirit: A values-based approach to keeping a healthy balance in one's life. Carson City, NV: Author.
- The Change Companies. (2007). Abuse or addiction?: The drug abuse roller coaster: Part of the keep it direct and simple series [Participant journal]. Carson City, NV: Author.
- The Change Companies. (2007). Trauma in life [Participant journal]. Carson City, NV: Author.
- The Change Companies. (2008). Changing course [Participant journal]. Carson City, NV: Author.
- The Change Companies. (2010). Breaking the cycle: Getting started: Nonresidential drug abuse treatment [Participant journal]. Carson City, NV: Author.
- The Change Companies & T'Shuva, B. (2006). Staying free from alcohol & drugs: Preparing for the journey: A program of positive development for Jewish youth. Carson City, NV: The Change Companies.

Non-program-specific quality assurance materials from the Change Companies:

- Hoffman, N. G. (2000). CAAPE (Comprehensive Addictions and Psychological Evaluation) manual. Carson City, NV: The Change Companies.
- Hoffman, N. G. (2000). Comprehensive Addictions and Psychological Evaluation (CAAPE). Carson City, NV: The Change Companies.
- Hoffman, N. G. (2000). Comprehensive Addictions and Psychological Evaluation (CAAPE) summary data. Carson City, NV: The Change Companies.

- Hoffmann, N. G., Mee-Lee, D., & Shulman, G. D. (2005). Outcome Assessment and Reporting System (OAARS). Carson City, NV: The Change Companies.
- Hoffmann, N. G., Mee-Lee, D., & Shulman, G. D. (2005). Outcome Assessment and Reporting System (OAARS): Manual. Carson City, NV: The Change Companies.
- Hoffmann, N. G., Mee-Lee, D., & Shulman, G. D. (2005). Outcome Assessment and Reporting System (OAARS): Tabulations and data analysis. Carson City, NV: The Change Companies.
- The Change Companies. (n.d.). Fidelity scoring definitions. Carson City, NV: Author.
- The Change Companies. (n.d.). The Change Companies fidelity tool. Carson City, NV: Author.
- The Change Companies. (n.d.). The Change Companies fidelity tool: Short form. Carson City, NV: Author.

Web sites:

- Interactive eJournals Web site, https://www.interactivejournaling.net/index1.php
- The Change Companies Web site, http://www.changecompanies.net

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	4.0	**4.0**

Dissemination Strengths

Participant journals are attractive and contain engaging exercises. Facilitator guides contain reproductions of the corresponding participant journals, along with core content information and facilitation tips and techniques. Numerous Interactive Journaling programs are available, giving implementers a variety of choices for meeting the needs of their client populations. In addition, the developer can customize a program to meet the needs (e.g., culture, language) of a specific population or to comply with State-specific requirements and regulations. Many training options are available in a variety of formats, including on- and off-site trainings and coaching and consultation via phone calls and Webinars. The developer has a team of consultants who are available to provide assistance on program implementation, staff selection, training options, assessment and outcome measurement, fidelity, and organizational development. A tool is available in long or short form to support program fidelity, and participant pre- and posttests are available to measure outcomes. In addition, the developer offers the Outcome Assessment and Reporting System, which can be used to collect longitudinal data throughout an entire treatment episode. Participant, facilitator, and training evaluations are available to assess program delivery.

Dissemination Weaknesses

No weaknesses were identified by reviewers.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Participant journals	$0.90-$9 per journal	Yes
Interactive Journaling facilitator guides	$15-$35 per guide	Yes
45-minute telephone orientation session for facilitators, clinicians, and supervisors	Free	No
1-day Orientation Training for facilitators, clinicians, and supervisors	• Off-site training in Carson City, NV: $1,000 for up to 15 participants • On-site training: $2,500 for up to 25 participants	No

2- to 3-day Facilitation Implementation Training for facilitators, clinicians, and supervisors	• Off-site training in Carson City, NV: $1,000 per day for up to 15 participants • On-site training: $2,500 for day 1 and $2,000 for days 2 and 3, for up to 25 participants	Yes
2-day Advanced Facilitator Training for facilitators, clinicians, and supervisors	• Off-site training in Carson City, NV: $1,000 per day for up to 15 participants • On-site training: $4,500 for up to 25 participants	No
Distance learning, e-learning, and Webinar modules for facilitators, clinicians, and supervisors (with continuing education credits ranging from 0.5 to 9.0 per module)	• For individual participants, $10-$25 per module • For agencies, $150-$1,000 per module for tailored Webinars	No
3-day, on- or off-site Training for Trainers	• Off-site training in Carson City, NV: $1,000 per day for up to 6 participants • On-site training: $6,500 for up to 10 participants	No
Phone, Webinar, or email technical assistance and consultation	Free	No
In-depth phone or Webinar coaching	Starts at $150 per hour	No
The Change Companies Fidelity Tool (long and short forms)	Free	No
Facilitator evaluations, facilitator self-evaluations, and supervisor/observer evaluation of facilitators	Free	No
Training evaluation and observation and feedback form	Free	No
Participant program evaluation forms	Included with facilitator guide or available online	No
Participant pre- and posttests	Included with facilitator guide or available online	No
Outcome Assessment and Reporting System (OAARS)	$99 for a package of 50 OAARS tools, reporting tables, tabulation sheets, and administration manual	No

Additional Information

The Change Companies can customize journals to fit the needs of an implementing agency, and site licenses for distance learning, e-learning, and Webinar modules are available for agencies.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Cheesman, F. L., II, Dancy, D., Jones, A., & Hardenbergh, D. (2005, September). An examination of recidivism of offenders receiving services from the Virginia Alcohol Safety Action Program. Williamsburg, VA: National Center for State Courts.

Davidson, P. (2007, March). Use of recidivism rates by state agencies: Recidivism rates for the Alcohol Safety Action Program (Audit Control No. 06-30035B-07). Juneau, AK: Alaska State Legislature, Legislative Budget and Audit Committee, Division of Legislative Audit. Available at http://www.legaudit.state.ak.us/pages/audits/2007/pdf/30035brpt.pdf

* Loudenburg, R. (2008). South Dakota Public Safety DUI Program: Four year evaluation report. Data period January 2004 through December 2007 (Prepared for the Office of Highway Safety, South Dakota Department of Public Safety). Salem, SD: Mountain Plains Evaluation.

Moore, M. J. (2011, May). Examining participants' motivation to change in residential drug abuse program graduates: Comparing "stages of change" assessment data with post-release status. Unpublished doctoral dissertation, University of Minnesota, Minneapolis. Available at http://conservancy.umn.edu/bitstream/108206/1/Moore_umn_0130E_11879.pdf

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* Proctor, S. L., Hoffman, N. G., & Allison, S. (2012). The effectiveness of Interactive Journaling in reducing recidivism among substance-dependent jail inmates. International Journal of Offender Therapy and Comparative Criminology, 56(2), 317-332.

Raney, V. K., Magaletta, P., & Hubbert, T. A. (2006). Perception of helpfulness among participants in a prison-based residential substance abuse treatment program. Journal of Offender Rehabilitation, 42(2), 25-34.

Smith, D. C., Hall, J. A., Williams, J. K., An, H., & Gotman, N. (2006). Comparative efficacy of family and group treatment for adolescent substance abuse. American Journal on Addictions, 15(Suppl. 1), 131-136.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.changecompanies.net**

Modified Therapeutic Community for Persons With Co-Occurring Disorders

The Modified Therapeutic Community (MTC) for Persons With Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use disorders and mental disorders. MTC is a structured and active program based on community-as-method (that is, the community is the treatment agent) and mutual peer self-help. A comprehensive treatment model, MTC adapts the traditional therapeutic community (TC) in response to the psychiatric symptoms, cognitive impairments, and reduced level of functioning of the client with co-occurring disorders. Treatment encompasses four stages (admission, primary treatment, live-in reentry, and live-out reentry) that correspond to stages within the recovery process. The stage format allows gradual progress, rewarding improvement with increased independence and responsibility. Goals, objectives, and expected outcomes are established for each stage and are integrated with goals specific to each client in an individual treatment plan. Staff members function as role models, rational authorities, and guides.

The MTC model retains most of the key components, structure, and processes of the traditional TC but makes three key adaptations for individuals with co-occurring disorders: It is more flexible, less intense, and more personalized. For example, MTC reduces the time spent in each activity, deemphasizes confrontation, emphasizes orientation and instruction, uses fewer sanctions, is more explicit in acknowledging achievements, and accommodates special developmental needs.

When used in prison settings, MTC has included additional programmatic and operational adaptations to address the particular circumstances of offenders with co-occurring disorders. Programmatic alterations have included an emphasis on criminal thinking and behavior that recognizes the interrelationships of substance abuse, mental illness, and criminality, while operational adjustments have included adding security personnel to the treatment team and making other changes to comply with the security requirements of correctional facilities. In other community applications, outpatient substance abuse treatment programs have adopted certain features of the MTC model to improve services for their clients who have co-occurring disorders.

Descriptive Information

Areas of Interest	Co-occurring disorders
Outcomes	**Review Date: March 2008** 1: Substance use 2: Criminal behavior 3: Psychological problems 4: Employment 5: Economic benefit 6: Housing stability
Outcome Categories	Alcohol Cost Crime/delinquency Drugs Employment Homelessness Mental health
Ages	26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified

Settings	Residential Outpatient Correctional
Geographic Locations	Urban Suburban
Implementation History	First implemented in 1992, MTC for Persons With Co-Occurring Disorders has been used at 25 sites with an estimated 21,000 participants. Outside the United States, the intervention has been implemented in Auckland, New Zealand, and Montreal, Canada.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Adaptations to the intervention have been made for a prison population, primarily to incorporate a programmatic emphasis on criminal thinking. In addition, some features of the intervention have been added to intensive day treatment programs in community outpatient substance abuse treatment centers.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: March 2008

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

De Leon, G., Sacks, S., Staines, G., & McKendrick, K. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. American Journal of Drug and Alcohol Abuse, 26(3), 461-480.

French, M. T., McCollister, K. E., Sacks, S., McKendrick, K., & De Leon, G. (2002). Benefit-cost analysis of a modified therapeutic community for mentally ill chemical abusers. Evaluation and Program Planning, 25, 137-148.

Study 2

Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. Behavioral Sciences and the Law, 22(4), 477-501.

Sullivan, C. J., McKendrick, K., Sacks, S., & Banks, S. (2007). Modified therapeutic community treatment for offenders with MICA disorders: Substance use outcomes. American Journal of Drug and Alcohol Abuse, 33(6), 823-832.

Study 3

Sacks, S., McKendrick, K., Sacks, J. Y., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: Main outcomes. Journal of Substance Abuse Treatment, 34(1), 48-60.

Supplementary Materials

Sacks, S. (2007). CTCR interview protocols--Baseline & follow-up. Unpublished manuscript.

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

Sacks, S., Banks, S. M., McKendrick, K., Sacks, J. Y., & Cleland, C. M. (2007). Meta-analysis for single investigators and research teams. Manuscript submitted for publication.

Sacks, S., Sacks, J. Y., & De Leon, G. (1999). Treatment for MICAs: Design and implementation of the modified TC. Journal of Psychoactive Drugs, 31(1), 19-30.

Sacks, S., Sacks, J. Y., & Stommel, J. (2003). Modified therapeutic community program for inmates with mental illness and chemical abuse disorders. Corrections Today, 65(6), 90-99.

Outcomes

Outcome 1: Substance use	
Description of Measures	In one study, substance use was evaluated using three self-report measures: frequency of alcohol intoxication, number of different types of illegal drugs used (0-17), and highest frequency of illegal drug use on a scale from 0 (none) to 8 (more than once daily). All three reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, substance use was evaluated using six self-report measures across the first 12 months after release from prison: any illegal drug use, alcohol used to intoxication, any substance use (combined measure of drug use and alcohol used to intoxication), frequency of alcohol used to intoxication, drug use severity, and days until substance use (relapse).
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, low-intensity MTC clients reported significantly less frequent alcohol intoxication ($p < .05$), fewer types of illegal drugs used ($p < .01$), and less frequent drug use ($p < .01$) than usual care clients. These differences remained at the long-term follow-up ($p < .05$, $p < .05$, and $p < .01$, respectively). • At the 12-month follow-up, low-intensity MTC clients reported significantly fewer types of illegal drugs used ($p < .01$) and less frequent illegal drug use ($p < .01$) than moderate-intensity MTC clients. These differences remained at the long-term follow-up ($p < .05$ and $p < .01$, respectively), at which time low-intensity MTC clients also reported less frequent alcohol intoxication than moderate-intensity MTC clients ($p < .05$). In addition, more low-intensity than moderate-intensity MTC clients were retained in treatment for 12 months (56% vs. 34%, $p < .002$). • At the 12-month follow-up, MTC clients who received 12 months of treatment (treatment completers) in either the low-intensity ($p < .01$) or the moderate-intensity ($p < .05$) condition reported less substance use than clients who received usual care for at least 9 months. • At the long-term follow-up, clients who received at least 12 months of treatment (treatment completers) in both MTC conditions reported less frequent alcohol intoxication ($p < .01$), fewer types of illegal drugs used ($p < .01$), and less frequent illegal drug use ($p < .001$) than clients who received usual care for at least 9 months. In a randomized controlled trial (RCT), male prison inmates with co-occurring disorders were assigned either to a 12-15 month in-prison MTC program modified for a prison population, followed by a voluntary, 6-month aftercare MTC program in a community corrections facility after release, or to a mental health treatment condition of variable duration (11 months, on average). Adaptations to MTC included a programmatic emphasis on criminal thinking and behavior, adjustments to comply with security guidelines, inclusion of security personnel on the treatment team, psychoeducational classes, and cognitive behavioral protocols. The control condition consisted of psychiatric medication services, weekly individual therapy and counseling, and mandated cognitive behavioral and anger management group therapy. • At the 12-month postrelease follow-up, both groups showed improvement in substance use, illegal drug use, and alcohol used to intoxication. However, relative to control group participants, a significantly smaller percentage of MTC participants reported substance use (56% vs. 31%, $p < .01$), illegal drug use (44% vs. 25%, $p < .05$), and alcohol used to intoxication (39% vs. 21%, $p < .05$). • At the 12-month postrelease follow-up, compared with MTC participants, control group participants were nearly three times as likely to report substance use and alcohol used to intoxication (odds ratio = 2.94) and more than twice as likely to report illegal drug use (odds ratio = 2.33). The effect sizes were medium and small, respectively. • On average, MTC participants relapsed later than control group participants (3.7 months vs. 2.6 months, $p < .05$). • At the 12-month postrelease follow-up, MTC participants had greater decreases in reported severity of drug use (82% vs. 64%, $p < .05$) and alcohol used to intoxication (63% and 28%, $p < .05$) relative to control group participants.

	• Among clients with a history of polydrug use, MTC participants had larger reductions in reported substance use (odds ratio = 4.00), illegal drug use (odds ratio = 2.63), and alcohol used to intoxication (odds ratio = 3.45) than control group participants at the 12-month postrelease follow-up. These effect sizes ranged from small to medium.
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	2.7 (0.0-4.0 scale)

Outcome 2: Criminal behavior	
Description of Measures	In one study, criminal behavior was measured by two self-report items: number of different types of crimes committed (0-16) and total number of crimes committed for each type reported on a scale from 0 (none) to 9 (more than 500). Self-reports of criminal behavior were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, criminal behavior was measured by the following three self-report items across the first 12 months after release from prison: reincarceration, number of new illegal activities (0-17), and drug/alcohol-related offenses. Self-reports were cross-checked against department of correction records.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, clients had a decrease in reported crimes committed and crime types regardless of treatment condition ($p < .01$). However, low-intensity MTC clients reported fewer crimes committed than moderate-intensity clients ($p < .04$). • At the long-term follow-up, low- and moderate-intensity MTC clients reported fewer crimes committed ($p < .001$ and $p < .05$, respectively) and fewer crime types ($p < .001$ and $p < .05$, respectively) than usual care clients. • At the 12-month follow-up, MTC clients who received at least 12 months of residential treatment (treatment completers) in either the low-intensity ($p < .01$) or moderate-intensity ($p < .05$) conditions reported fewer crimes committed and fewer crime types than clients who received usual care for at least 9 months. This difference continued to the long-term follow-up ($p < .001$). In an RCT, male prison inmates with co-occurring disorders were assigned either to a 12-15 month in-prison MTC program modified for a prison population, followed by a voluntary, 6-month aftercare MTC program in a community corrections facility after release, or to a mental health treatment condition of variable duration (11 months, on average). Adaptations to MTC included a programmatic emphasis on criminal thinking and behavior, adjustments to comply with security guidelines, inclusion of security personnel on the treatment team, psychoeducational classes, and cognitive behavioral protocols. The control condition consisted of psychiatric medication services, weekly individual therapy and counseling, and mandated cognitive behavioral and anger management group therapy. • At the 12-month postrelease follow-up, MTC participants had significantly lower reincarceration rates than individuals in the control condition (9% vs. 33%, $p < .01$), a difference that reflects a medium effect size (odds ratio = 3.85). MTC clients who chose to participate in the aftercare program had an even lower reincarceration rate than control group participants (5% vs. 33%, $p < .02$), a difference that reflects a large effect size (odds ratio = 7.69). • Time in treatment across any of the three conditions was a significant predictor of both reincarceration and criminal activity at the 12-month postrelease follow-up ($p < .01$). The average time to reincarceration was longest for MTC clients who participated in the aftercare program (170 days) and shortest for control group participants (108 days). • Compared with control group participants, MTC participants who participated in the aftercare program had significantly lower rates of criminal activity in general (67% vs. 42%, $p < .05$)

	and lower rates of criminal activity related to alcohol and drug use (58% vs. 30%, $p < .03$) at the 12-month postrelease follow-up. These findings reflect a small effect size (odds ratio = 2.33 and 2.78, respectively).
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Outcome 3: Psychological problems	
Description of Measures	In one study, psychological problems (depression and anxiety symptoms) were measured using the Beck Depression Inventory (BDI) and the Short Form of the Taylor Manifest Anxiety Scale. The BDI is a 21-item self-report instrument that measures past-week depressive symptoms. Total scores vary from 0 to 63 and indicate whether depression is minimal (0-13), mild (14-19), moderate (20-28), or severe (29-63). The Short Form of the Taylor Manifest Anxiety Scale is a 20-item, true/false, self-report questionnaire measuring past-week anxiety symptoms. Self-reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average. In another study, psychological problems were measured using the Global Appraisal of Individual Needs (GAIN) at baseline and the 12-month follow-up. The GAIN is a standardized, semistructured interview with eight main sections (background, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational) that is designed to support the diagnosis, placement, and outcome monitoring of patients and the economic analysis of an intervention.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, low-intensity MTC clients reported fewer depression symptoms than moderate-intensity MTC clients ($p < .02$). • At the long-term follow-up, low-intensity MTC clients reported fewer depression symptoms ($p < .001$) and fewer anxiety symptoms ($p < .03$) than clients who received usual care. • At the 12-month follow-up, clients who received 12 months of treatment (treatment completers) in both MTC conditions reported fewer depression and anxiety symptoms than clients who received usual care for at least 9 months ($p < .05$). In an RCT, clients with co-occurring disorders who were admitted to an outpatient substance abuse day treatment program were assigned to one of two intensive conditions: MTC modified for day treatment or usual care. Both conditions consisted of 3 hours of treatment per day, 3 days per week. The modified MTC condition incorporated community-enhancing meetings for dual recovery taken from the residential MTC model and added a psychoeducational seminar, trauma-informed addictions treatment, and case management. Usual care was a basic day treatment program that provided individual as well as group therapy and counseling that focused on substance use and relapse prevention. • At the 12-month follow-up, MTC clients had greater decreases in reported emotional problems ($p = .04$) and any emotional or psychological problems ($p < .001$) than usual care clients.
Studies Measuring Outcome	Study 1, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 4: Employment	

Description of Measures	Employment was evaluated using one self-report measure. Response options were 0 (none), 1 (part-time irregular or odd jobs), 2 (part-time regular), and 3 (full-time). Self-reports were obtained at baseline, at 12 months after baseline, and at each client's last follow-up point (long-term follow-up), which was more than 24 months after baseline, on average.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • At the 12-month follow-up, clients in both MTC conditions reported increased employment relative to usual care clients ($p < .001$). This difference remained at the long-term follow-up ($p < .001$ for low intensity and $p < .01$ for moderate intensity). • At the 12-month follow-up, MTC clients who received at least 12 months of treatment (treatment completers) in both MTC conditions had a greater increase in reported employment than clients who received usual care for at least 9 months ($p < .001$). This finding remained at the long-term follow-up ($p < .001$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.8 (0.0-4.0 scale)

Outcome 5: Economic benefit	
Description of Measures	Economic benefit was measured as the average incremental financial benefit over the cost of each condition, the net financial benefit over the cost of each condition, and the benefit-to-cost ratio associated with each condition, calculated in 1994 dollars. Financial benefits were evaluated as the estimated cost savings to society expected to accrue from self-reported declines in criminal activity, increased productivity (employment earnings), and decreased health care utilization occurring from 12 months before to 12 months after admission (baseline). Monetary conversion factors (unit cost estimates) were applied to changes in criminal activity, employment earnings, and health care utilization. The economic benefits of treatment were defined as the dollar value associated with changes in each of these outcome domains. Costs associated with the study conditions were calculated using the Drug Abuse Treatment Cost Analysis Program (DATCAP), an analysis package that estimates both the accounting and economic costs of program implementation, including the full value of all resources, such as donations and subsidies.
Key Findings	Homeless clients with co-occurring disorders were sequentially assigned to a low-intensity MTC condition, a moderate-intensity MTC condition, or usual care. Compared with the high-intensity MTC condition, the low-intensity condition placed fewer demands on clients (e.g., clients had more freedom to leave the facility) and provided clients with more staff assistance. Usual care incorporated a variety of treatment and nontreatment options that were typically less specific to the needs of homeless clients with co-occurring disorders, not as well organized, and less cohesive in perspective or approach relative to the MTC conditions. • On the basis of increased employment reported by MTC clients compared with usual care clients at the 12-month follow-up, the economic benefit per MTC client relative to usual care client was \$720 ($p = .01$). • On the basis of decreased health care utilization reported by MTC clients compared with usual care clients at the 12-month follow-up, the economic benefit per MTC client relative to usual care client was \$17,613 ($p = .01$). • The total average cost savings to society associated with less health care utilization, less criminal activity, and more employment reported by MTC relative to usual care clients was \$305,273 ($p = .01$) per MTC client. When adjusted for outlying MTC clients, this figure decreased to \$149,851 but remained significant ($p = .01$). • The average incremental economic benefit associated with less health care utilization, less criminal activity, and more employment reported by MTC relative to usual care clients was \$273,698 ($p = .05$) per MTC client. When adjusted for outlying MTC clients, this figure decreased to \$105,618 but remained significant ($p = .05$).

	• The net benefit estimate ($253,337) and benefit-to-cost ratio (5:1) associated with a client participating in MTC relative to usual care suggested the economic benefit of MTC, but these findings were not statistically significant.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.4 (0.0-4.0 scale)

Outcome 6: Housing stability	
Description of Measures	Housing stability was measured using the GAIN, a standardized, semistructured interview with eight main sections (background, substance use, physical health, risk behaviors, mental health environment, legal, and vocational) that is designed to support the diagnosis, placement, and outcome monitoring of patients and the economic analysis of an intervention.
Key Findings	In an RCT, clients with co-occurring disorders who were admitted to an outpatient substance abuse day treatment program were assigned to one of two intensive conditions: MTC modified for day treatment or usual care. Both conditions consisted of 3 hours of treatment per day, 3 days per week. The modified MTC condition incorporated community-enhancing meetings for dual recovery taken from the residential MTC model and added a psychoeducational seminar, trauma-informed addictions treatment, and case management. Usual care was a basic day treatment program that provided individual as well as group therapy and counseling that focused on substance use and relapse prevention. • At the 12-month follow-up, clients in both conditions had an increase in reported days rent was paid, a decrease in reported time spent in a shelter/emergency housing, and a decrease in reported time in a voluntary housing facility ($p < .05$). However, MTC clients reported more days of paying rent for housing than usual care clients ($p = .04$).
Studies Measuring Outcome	Study 3
Study Designs	Experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	26-55 (Adult)	75.4% Male 24.6% Female	70.2% Black or African American 18.1% Hispanic or Latino 11.7% White
Study 2	26-55 (Adult)	100% Male	48.9% White 30.2% Black or African American 16.5% Hispanic or Latino 4.3% Race/ethnicity unspecified
Study 3	26-55 (Adult)	57.1% Female 42.9% Male	78.8% Black or African American 13.1% White 8.1% Hispanic or Latino

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Substance use	2.9	2.4	2.3	2.8	3.0	3.3	**2.7**
2: Criminal behavior	3.0	2.5	2.3	2.8	3.0	3.3	**2.8**
3: Psychological problems	3.8	3.8	2.0	2.5	3.0	2.8	**3.0**
4: Employment	3.0	2.5	2.0	2.5	3.0	3.5	**2.8**
5: Economic benefit	2.5	2.0	2.5	2.0	3.0	2.5	**2.4**
6: Housing stability	3.0	2.5	2.0	2.5	3.0	2.5	**2.6**

Study Strengths

Standard self-report instruments and measures were used and were augmented with collateral information in some cases (e.g., urine drug screens and department of correction records in the prison study). Self-reports of reincarceration are likely to be highly valid and reliable from the prison study, as they were checked against department of correction records. In the outpatient treatment study, housing was a good index of increased stability and reduced risk for homelessness. Intervention training was carried out by experts who provided ongoing supervision. The DATCAP economic analyses were strong in the homeless study.

Study Weaknesses

Reliability for the self-report of substance use and psychological problems was not specifically calculated in these study samples. In the absence of any independent verification, the validity of self-reported crime types and number of crimes committed as true index measures for criminal behavior in the homeless study is questionable. Additionally, there was no attempt to verify self-reported employment (e.g., using pay stubs) in the homeless study. Consequently, the cost-benefit analysis in the homeless study was weakened by the reduced reliability and validity of the behavioral change measures--self-reported criminal behavior and employment--on which it was based. There was no independent verification of intervention fidelity and no fidelity ratings for the usual care control groups in any of these studies.

Readiness for Dissemination

Review Date: March 2008

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Overview of MTC dissemination materials

PowerPoint slides for training and technical assistance series:

- Co-Occurring Substance Use and Mental Disorders (COD)--Diagnoses, Symptoms, and Clinical Tips
- Evidence-Based and Consensus Practices for Treatment of Persons With Co-Occurring Disorders
- Modified Therapeutic Communities for People With Co-Occurring Disorders--Research Findings
- Modified Therapeutic Community for Clients With Mental Illness & Chemical Abuse (MICA) Disorders--Description of the Program
- Modified Therapeutic Community (MTC)--Principles of Implementation
- Overview of Screening and Assessment

Sacks, S., De Leon, G., Bernhardt, A., & Sacks, J. (1996). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment manual. New York: National Development and Research Institutes/Center for Therapeutic Community Research.

Sacks, S., Sacks. J. Y., & De Leon, G. (1999). Treatment for MICAs: Design and implementation of the modified TC. Journal of Psychoactive Drugs, 31(1), 19-30. PubMed

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources

3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.5	2.5	2.5	**2.8**

Dissemination Strengths

The well-designed treatment manual provides program content, clear steps for implementing the program, and information on the intervention's goals and intended audience. Training and consultation are provided by the program developers to support initial and ongoing implementation. Several tools are provided to support quality assurance.

Dissemination Weaknesses

It may be difficult for implementers to see how the program materials fit together to frame an overall approach to implementation. Limited information is provided on staff roles, especially their interrelationships. The training materials include only minimal discussion of staff supervision. Detailed information addressing continued direct supervision of front-line staff to support quality assurance is not provided. The overall design for quality assurance is unclear.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Program materials	Free	Yes
2-day stakeholder/system introduction	$5,000 plus travel expenses	No
3-day intensive staff training	$6,000 plus travel expenses	Yes
2-day follow-up training	$2,500 plus travel expenses	No
2-day site observation and technical assistance visit	$2,000 plus travel expenses	No
Biweekly technical assistance phone calls (for months 1-6 of implementation)	$125 per hour	No
Monthly technical assistance phone calls (for months 7-12 of implementation)	$125 per hour	No
TC Scale of Essential Elements Questionnaire (SEEQ)	Free	No
TCU Organizational Scales (TCU ORC)	Free	No
Dual Diagnosis Capability in Addiction Treatment (DDCAT)	Free	No
Dual Diagnosis Capability in Mental Health Treatment (DDMHT)	Free	No

Additional Information

The average cost of providing this intervention to one client with co-occurring disorders for 12 months is $29,255 (1994 estimates), about the same as the cost of providing 12 months of standard residential treatment ($29,638, also 1994 estimates).

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

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

* Sacks, S., McKendrick, K., Sacks, J. Y., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: Main outcomes. Journal of Substance Abuse Treatment, 34(1), 48-60.

* Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders: Crime outcomes. Behavioral Sciences and the Law, 22(4), 477-501.

* Sullivan, C. J., McKendrick, K., Sacks, S., & Banks, S. (2007). Modified therapeutic community treatment for offenders with MICA disorders: Substance use outcomes. American Journal of Drug and Alcohol Abuse, 33(6), 823-832.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.ndri.org/ctrs/cirp.html**

Moral Reconation Therapy

Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months.

Descriptive Information

Areas of Interest	Mental health treatment Substance abuse treatment Co-occurring disorders
Outcomes	**Review Date: May 2008** 1: Recidivism 2: Personality functioning
Outcome Categories	Crime/delinquency Social functioning
Ages	13-17 (Adolescent) 18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Black or African American White Race/ethnicity unspecified Non-U.S. population
Settings	Correctional
Geographic Locations	No geographic locations were identified by the developer.
Implementation History	MRT has been implemented in a variety of treatment settings in more than 45 States and in Australia, Bermuda, and Canada. Several States have systemwide implementations of MRT. It is estimated that more than 1 million individuals have participated in the intervention.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	While MRT was first designed as a criminal justice-based drug treatment method, a host of other treatment adaptations have been made, including more individualized programs that deal with parenting, spiritual growth, anger management, juvenile offenders, sexual and domestic violence, and treatment and job readiness. Different workbooks based on the fundamental MRT concepts exist for each of these areas.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.

IOM Prevention Categories	IOM prevention categories are not applicable.

Quality of Research

Review Date: May 2008

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Deschamps, T. (1998). MRT: Is it effective in decreasing recidivism rates with young offenders? Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.

Study 2

Little, G., Robinson, K. D., Burnette, K. D., & Swan, S. (1999). Successful ten-year outcome data on MRT-treated felony offenders: Treated offenders show significantly lower reincarceration in each year. Cognitive-Behavioral Treatment Review, 8(1), 1-3.

Little, G. L., & Robinson, K. D. (1989). Effects of Moral Reconation Therapy upon moral reasoning, life purpose, and recidivism among drug and alcohol offenders. Psychological Reports, 64, 83-90.

Study 3

Kirchner, R. A., Byrnes, E. C., Kirchner, T. R., & Heckert, A. O. (2007). Effectiveness and impact of program delivery: Evaluation of the Thurston County Drug Court Program--Part II. Annapolis, MD: Glacier Consulting.

Study 4

Krueger, S. (1997). Five-year recidivism study of MRT-treated offenders in a county jail. Cognitive Behavioral Treatment Review, 3-4, 3.

Study 5

Godwin, G., Stone, S., & Hambrock, K. (1995). Recidivism study: Lake County, Florida Detention Center. Cognitive Behavioral Treatment Review, 4, 12.

Supplementary Materials

Little, G. L., & Robinson, K. D. (1988). Moral Reconation Therapy: A systematic step-by-step treatment system for treatment resistant clients. Psychological Reports, 62, 135-151.

Wilson, D. B., Bouffard, L. A., & MacKenzie, D. L. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. Criminal Justice and Behavior, 32(2), 172-204.

Outcomes

Outcome 1: Recidivism	
Description of Measures	In some studies, recidivism was defined as the rate at which individuals were rearrested on new criminal charges, while other studies limited recidivism to a conviction of a subsequent crime(s). Data from each study were obtained from various databases, including Canada's Offender Management System (OMS), the Washington State Institute for Public Policy (WSIPP) Statewide Criminal History database, and computer-generated searches of local and national arrest records and jail records.
Key Findings	One study was conducted in Ontario, Canada, with juvenile male clients sentenced by a judge to an open custody facility, which is a midpoint on the continuum between prison and return to the community. In this type of facility, the offenders are not secured behind bars, and if the clients decide to leave, the staff are not required to intervene physically, but the offenders will receive a new charge when they are apprehended again. In this study, clients who participated in MRT had a conviction rate of 46% during the study period, compared with 57% of clients from a different open-custody facility that did not offer MRT. Further, the average number of reoffenses for the treatment group was 4.1, while the average number of reoffenses for the control group was 5.7 ($p = .043$).

	In another study, after 1 year of release, adult male felony inmates who participated in MRT showed a reincarceration rate that was two-thirds lower than that of a control group of inmates who had volunteered for the MRT program but did not receive it due to limited treatment funding. In all subsequent years (up to 10 years after the original incarceration), the treated group's reincarceration rate was approximately one-fifth to one-third lower than controls (p values ranging from .05 to .001). For example, after 10 years of release, MRT-treated subjects showed a 45.7% reincarceration rate compared with 64.6% in controls. The Thurston County Drug Court Program is a judicially led drug court specifically designed to facilitate the treatment and rehabilitation of nonviolent, substance-abusing adult felons. Male and female clients who participated in MRT were rearrested for any offense at a rate of 20%, compared with 45.3% for a matched control group ($p < .001$). Further, the arrest rate for felony drug offenses was significantly lower for the clients who participated in MRT than for those in the control group (7% vs. 16%; $p < .001$). Additionally, graduates of the program were compared with clients who had been exposed to some amount of the intervention but were terminated from their programs. Graduates had significantly fewer rearrests than their counterparts who did not successfully complete the program (27% vs. 53%; $p < .001$). A fourth study examined the recidivism of adult male inmates of a short-term county jail. Inmates who participated in MRT had a 45% rearrest rate in the 4 years after being released from jail, compared with 67% for a control group who did not participate in MRT ($p < .05$). In a fifth study, adult male inmates of a short-term county detention center who participated in MRT had a reincarceration rate of 11.3% 1 year after release and 25.3% 2 years after release. Inmates who did not participate in MRT had significantly higher recidivism rates at 1 year (29.7%; $p < .001$) and 2 years (37.3%; $p < .01$) after release.
Studies Measuring Outcome	Study 1, Study 2, Study 3, Study 4, Study 5
Study Designs	Quasi-experimental
Quality of Research Rating	1.9 (0.0-4.0 scale)

Outcome 2: Personality functioning	
Description of Measures	Participants responded to the short form (20 questions) of the Purpose in Life Questionnaire, which estimates perceived purpose in life. Participants also completed the Defining Issues Test, an objective paper-and-pencil test that yields percentile scores indicating individuals' capabilities for six stages of moral reasoning. Of particular interest in this study was the degree of "principled reasoning," represented by the sum of the scores for the two highest stages of moral reasoning. People who make their decisions from levels of principled reasoning tend to be guided by concerns of justice, equality, and basic human rights.
Key Findings	Among adult male offenders participating in the Drug Abuse Program (a closed therapeutic community operated within the prison compound), there was a significant positive correlation between the last MRT step completed at the time of the initial testing (after 6 months of program implementation) and the degree of principled reasoning ($p = .03$) and perceived purpose in life ($p = .01$). Further, there were significant improvements in universal-ethical principle (following one's conscience) levels ($p = .01$), the percent of principled reasoning ($p = .02$), and perceived purpose in life ($p = .01$) from testing conducted upon entry to retesting at the completion of MRT's Step 7. Similarly, among adult male inmates participating in the Alcohol Treatment Unit (a similar unit to the Drug Abuse Program, operated independently, but in close proximity), there was significant improvement in the percent of principled reasoning ($p = .01$) and perceived purpose in life ($p = .05$) from testing conducted upon entry to retesting the day before release from the program.
Studies Measuring Outcome	Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.2 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	13-17 (Adolescent) 18-25 (Young adult)	100% Male	100% Non-U.S. population
Study 2	18-25 (Young adult) 26-55 (Adult)	100% Male	80% Black or African American 20% Race/ethnicity unspecified
Study 3	18-25 (Young adult) 26-55 (Adult)	65.2% Male 34.8% Female	92.1% White 7.9% Race/ethnicity unspecified
Study 4	18-25 (Young adult) 26-55 (Adult)	89% Male 11% Female	Data not reported/available
Study 5	18-25 (Young adult) 26-55 (Adult)	100% Male	Data not reported/available

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Recidivism	2.0	2.0	1.0	3.0	1.5	2.0	**1.9**
2: Personality functioning	3.5	3.5	1.0	1.8	1.5	2.0	**2.2**

Study Strengths

Reliability and validity of the two personality functioning measures are well documented. The use of a treatment manual that incorporates milestones for program completion contributes to implementation fidelity. Missing data do not appear to have been an issue.

Study Weaknesses

Length of stay at a facility was often too short for participants to have attained the recommended length of time in the treatment program; as a result, positive results from program completion may be confounded with the effects of longer incarceration. Additional "extensive" support services provided in aftercare programs may be another confounding factor. More information could have been gathered and reported on the intervention and comparison groups, allowing for more appropriate statistical analyses and the use of analyses to control for alternative explanations of effects. Reliance on statewide databases limits the accuracy of recidivism rates; recidivism may occur in other States without being documented. The use of the Defining Issues Test as an outcome measure may reflect participants' verbal ability in addition to moral reasoning; additionally, a significant percentage of scores on the Defining Issues Test were dropped from analyses, with no correction indicated. In several studies, type 1 error rate inflation of the multiple chi-square analyses is a concern.

Readiness for Dissemination

Review Date: May 2008

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Little, G., & Robinson, K. D. (1995). Moral Reconation Therapy: Counselor's handbook. Memphis, TN: Eagle Wing Books.

Little, G. L., & Robinson, K. D. (1996). How to escape your prison: A Moral Reconation Therapy workbook. Memphis, TN: Eagle Wing Books.

Quality assurance materials:

- Comments on Video Quality Assurance Services
- Examples of Quality Assurance Reports
- Fidelity Checklist
- Moral Reconation Therapy: Implementation Questionnaire
- Quality Assurance Checklist of an Ongoing MRT Group
- Quality Assurance Services Brochure

Training materials:

- Moral Reconation Therapy: Advanced Training Curriculum
- Moral Reconation Therapy: Training Manual
- Moral Reconation Therapy: Training Slides

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
2.0	3.8	3.0	**2.9**

Dissemination Strengths

Implementation materials are engaging and audience appropriate. The counselor handbook provides helpful hints for facilitating effective groups and addresses common intervention pitfalls. A comprehensive initial training package, coupling didactic teaching methods with extensive role-play, is available to implementers. Implementation checklists, video tape review, and other quality assurance tools help ensure implementation fidelity and therapist competence. Advanced training that addresses the appropriate use of quality assurance tools is also provided.

Dissemination Weaknesses

Given the complexity of this intervention, additional information is needed on the required training and skill level for group facilitators and administrators. Guidance is not provided on how to integrate this intervention with existing criminal justice and mental health systems. The level of ongoing coaching and consultation available to implementers is unclear. Little guidance is provided to implementers to support outcomes measurement.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
MRT client workbook	$25 per participant	Yes
4-day, off-site initial training (includes quality assurance tools and services)	$600 for first person, $500 for each additional person from the same agency	Yes, one initial training option is required
On-site initial training (includes quality assurance tools and services)	Varies depending on site needs	Yes, one initial training option is required
2-day advanced training	$300 per person	No
On-site consultation	$450 per day	No
Video consultation	$150 per session	No

Additional Information

Volume discounts are available.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Burnett, W. L. (1996). Treating post-incarcerated offenders with Moral Reconation Therapy: A one-year recidivism study. Unpublished research project report, University of Phoenix.

* Deschamps, T. (1998). MRT: Is it effective in decreasing recidivism rates with young offenders? Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.

Grandberry, G. (1998). Moral Reconation Therapy evaluation final report 1998. Olympia, WA: Washington State Department of Corrections, Planning and Research Section.

Hanson, G. (2000). Pine Lodge Intensive Inpatient Treatment Program. Olympia, WA: Washington State Department of Corrections, Planning and Research Section.

Little, G. L. (2002). Evaluation of the Correctional Counseling, Inc., Therapeutic Community Program at the Tennessee Prison for Women. Unpublished report, Tennessee Department of Corrections, Nashville, TN.

Little, G. L., & Robinson, K. D. (1988). Moral Reconation Therapy: A systematic, step-by-step treatment system for treatment resistant clients. Psychological Reports, 62, 135-151.

* Little, G. L., & Robinson, K. D. (1989). Effects of Moral Reconation Therapy upon moral reasoning, life purpose, and recidivism among drug and alcohol offenders. Psychological Reports, 64, 83-90.

Little, G. L., Robinson, K. D., & Burnette, K. D. (1991). Treating drunk drivers with Moral Reconation Therapy: A three-year report. Psychological Reports, 69, 953-954.

Little, G. L., Robinson, K. D., & Burnette, K. D. (1991). Treating drug offenders with Moral Reconation Therapy: A three-year report. Psychological Reports, 69, 1151-1154.

Little, G. L., Robinson, K. D., & Burnette, K. D. (1993). Cognitive-behavioral treatment of felony drug offenders: A five-year recidivism report. Psychological Reports, 73, 1089-1090.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.ccimrt.com**
- **http://www.moral-reconation-therapy.com**