

SUBSTANCE USE TREATMENT
IN VICTORIAN CORRECTIONS:
SERVICE MIX AND STANDARDS

STAGE 1 REPORT: LITERATURE REVIEW ONLY

Report for Corrections Victoria

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STAGE 1 REPORT: LITERATURE REVIEW,

Project Methodology

The methodology for this project was developed in consultation with the project steering committee. The first stage of the project involved a review of the national and international literature on best practice in prison and community offender substance use programs, and on harm minimisation in prisons. This was approached in two ways – first, by a review of the published literature reporting the outcomes of correctional substance use treatment programs; and, second, by a review of good practice in offender rehabilitation programming more generally. Both were used to inform the site-visits and discussions with key stakeholders, leading to the development of the proposed service framework.

Methodology for the Literature Review

The literature reviewed for this report comes from a wide variety of sources. A narrative review of the literature was supplemented by a specific database search to yield program evaluations of offender programs. Four major bibliographic databases that include citations for criminal justice literature were searched: *CINCH*, (the Australian Criminology Database), *PsychINFO* (a database with 1.6 million citations relevant to psychology and related disciplines), *Sociological Abstracts* (a database with more than half a million citations relevant to sociology and related disciplines), and the *FAMILY* database (containing nearly 50,000 abstracted citations about or of relevance to Australian families). These databases were selected because they are the key citation sources in the criminal justice field, cover both Australian and international literature, and include high quality abstracts.

The following key search terms were used to search the databases. Only those items with a publication date from 1992 on (that is, items published in the last ten years) were included: Offender *or* corrections *or* reoffending And Substance use *or* drug *or* alcohol And Rehabilitation *or* treatment *or* intervention. These searches

yielded a total of more than 6,000 citations (989 citations from PsychInfo, 5,532 from CINCH and FAMILY, and 82 from Sociological Abstracts databases). Relevant papers and reports published on the world wide web, and those published prior to 1992, have also been reviewed in this report.

Methodology for the Consultations

The aim of the site visits was to discuss the current service mix with key stakeholders, and to elicit views about possible standards and models of practice. Information about current service provision was gathered in two ways.

Focus groups and interviews.

The consultancy team visited service providers and OSCS staff for a period of 11 days between 8th May and the 30th May 2003. The purpose of the site visits was not to review, audit or evaluate current programs. Rather, the consultations were intended to elicit sufficient information to provide the consultants with an overview of current service provision and to identify areas where current service provision might be strengthened. In this report, an attempt has been made to describe some of the major elements of rehabilitative practice in Victoria, rather than to comprehensively list all programs.

Review of documentation.

Previous reports, reviews and evaluations relevant to this project were forwarded by the OSCS. All service providers who participated in the consultations were also invited to provide any documentation relating to any programs or interventions that they saw as relevant to the project.

1. The Context for Victorian Offender Substance use Treatment

The use and abuse of licit and illicit drugs by offenders is a major concern for the Victorian criminal justice system. Approximately two thirds of all first-offenders who enter this system report a history of substance use that is directly related to their offending behaviour. For second and subsequent incarcerations, this figure increases to 80% for men and 90% for women (Victorian Prison Drug Strategy, 2002). Excessive alcohol use has also been implicated in the offending cycle, with research suggesting that between 41% and 70% of violent crimes committed in Victoria are done so under the influence of alcohol (Office of the Correctional Services Commissioner, 2000).

The National Drug Strategy (NDS), formerly the National Campaign Against Drug Abuse (NCADA), provides the basis for the development of all substance use treatment services in Australia. The guiding principle upon which the National Drug Strategy Framework is based is that of harm minimisation. Under this philosophy, governments acknowledge that where these risky behaviours continue to occur, they have a responsibility to develop and implement public health and law enforcement measures designed to minimise the harm that such behaviours can cause, both to individuals and to the community. The National Drug Strategy has had a major influence on how correctional agencies view substance use in prisons. Rather than adopt a strict law enforcement and zero tolerance approach to substance use in custody, prison administrators in recent years have sought to find ways to reduce the harms associated with substance use in prison. This has provided a basis for the development of substance use education programs to offenders, treatment programs aimed at reducing the consumption of illicit substances, and the implementation of drug substitution programs (e.g., methadone and other pharmacotherapies). The Victorian Prison Drug Strategy (2002) incorporates the fundamental tenets of the National Drug Strategy, including a focus on harm reduction/harm minimisation.

Recent years have also seen the parallel development of a systematic framework for reducing re-offending in Victoria, through the provision of treatment programs aimed largely at addressing the psychological causes of offending. The Offender Management Framework “is designed to ensure that prisoners are safe, spend their time constructively, and are provided with the necessary means to reduce their risk of re-offending, increase their skill levels, and enhance their resilience” (OCSC, 2003). Under this framework, program, management, and service needs are determined, to a large extent, by a front-end assessment of their risk of re-offending and those needs that are related to their offending. The Victorian Prison Drug Strategy (2002) is an attempt to embed the principles of harm minimisation within an offender rehabilitation framework directed at reducing re-offending.

In the last five years, a number of major reports have been prepared which have, in various ways, have addressed issues of how substance use programming in prisons might be integrated within the new offender management framework. These include reports by KPMG Consulting (1999), Care Australia (2000), and audits of specific prison programs by Ann Blyth (2001). More recently, Melbourne University Criminology Research and Evaluation Unit (2003) reviewed programs funded under the Turning the Tide initiative. These reports provide a useful overview of the shifting focus in service delivery for prison and community-based offender substance use treatment programs over the past ten years. In different ways, these reports all identify the need to develop standards for program design, delivery and evaluation; the need to develop more effective through-care structures for offenders leaving prison; and the need to introduce a greater focus within treatment on offending. These previous reports are summarised in the Appendix.

2. The Effectiveness of Correctional Substance use Treatment Programs: A Review of the Literature

Initiatives that aim to rehabilitate offenders and prevent re-offending are increasingly being seen as the core business of correctional systems around the world. Many of the recent developments in this area have been underpinned by a robust and growing body of evidence which suggests that offender rehabilitation programs, when appropriately designed and delivered, will significantly reduce re-offending. One of the most significant groups of offenders that have been identified as appropriate candidates for rehabilitation are those who use illicit substances or who are dependent on alcohol. Not only do many offenders experience problems in this area, but alcohol and drug use often leads directly to their offending (Day, Howells, Heseltine & Casey, 2003). Programs that can help offenders to reduce their substance use thus have great potential in terms of achieving significant reductions in re-offending and improved community safety.

In this review, we begin by providing a brief overview of the main types of rehabilitation program that have been offered to offenders with substance use problems in correctional settings, both institutional and community. There is a striking diversity in the programs offered to offenders (see Inciardi, 1993; Inciardi, Lockwood & Quinlan, 1993; Incorvaia & Baldwin 1997; Peters & May, 1992; see also Westmore & Walter, 1993 for an overview of Australian service responses). It is difficult, therefore, to describe what might be considered a typical program.

For the purposes of the review, prison substance use treatment programs have been (loosely) classified in terms of their level of intensity, based on the four-tier system developed by the Bureau of Prisons in the USA (Weinman & Lockwood, 1993). This system identifies education programs as the least intensive type of program, followed by non-residential programs, and then residential programs. The fourth level is comprised of transition programs that link prison and community services. We have attempted to provide a brief description of the types of program that have been described in the published literature for each level of programming, and, where possible, provide a short account of particular programs. Each level of

program is then discussed in terms of the recent literature on program effectiveness or outcomes. Treatment effectiveness can be defined in multiple ways, including reduction in substance use, reduction in re-offending, increased use of safer drug-related behaviours, and increased social and emotional well-being. All of these outcomes are clearly important.

From a correctional perspective, however, one of the most important outcomes will be a reduction in rates of re-offending and re-conviction. In Victoria (see above), drug and alcohol programs are delivered within a broad offender rehabilitation framework, a primary aim of which is to achieve significant reductions in re-offending.

In this review, it will become apparent that there is a growing evidence base suggesting that many programs will have positive effects on recidivism (e.g., Millson, Weekes & Lightfoot, 1995; Peters & May, 1992; Wexler, Falkin & Lipton, 1990), with reviews generally concluding that behavioural and multi-modal programs hold the most promise in terms of reducing crime (Husband & Platt, 1993; McMurrin, 1995). One of the most important recent reviews that has looked at the impact of prison based programs upon recidivism is a meta-analytic review conducted by Pearson and Lipton (1999). Meta-analysis is a statistical method for aggregating the results of many different studies involving large numbers of participants. Reviews of this type are generally considered to offer reasonably robust findings, and the findings of the Pearson and Lipton (1999) review are referred to extensively in this report.

Substance Use in Prison Programs

Whilst substance use in prison is commonly regarded as a continuation of pre-prison substance use, drug use may also either begin, or intensify, in prison (i.e., change from use of less harmful substances to more harmful ones). Prison administrations have a responsibility to guard against (a) creating new problems and (b) exacerbating problems that already exist. In addition, they have a duty of care towards their clients to ensure that basic health and safety needs are met. Screening for drug and alcohol problems to identify immediate needs for medical treatment upon arrival in prison, whilst not constituting a program in the context of this review, is

clearly an important component of service delivery. Similarly, medical and pharmacological treatments may also be important interventions for prisoners experiencing withdrawal. Detoxification treatments aim to move people into a place of relative safety, provide medical care, and to link people into treatment. Remand prisoners are particularly likely to require help with detoxification, assessment, advice on harm reduction, hepatitis B vaccination and referral to either further substance use treatment in prison or community agencies on release (Brooke, Taylor, Gunn & Maden, 1998).

Prisons are generally regarded as the logical place to start substance use treatment. Lipton (1994), for example, argues that the act of imprisonment presents an important opportunity for treatment, given that many drug users are unlikely to seek treatment by themselves, and that drug use and criminality are likely to continue after release. Arrival into custody also offers an opportunity to engage substance-misusing offenders into treatment that they would not otherwise choose. Brooke et al. (1998), in their study of remand prisoners, found that 23% of drug users requested treatment - a figure far higher than might be expected prior to imprisonment.

Prison Education Programs

Harm Reduction Programs

The overall goal of the National Drug Strategy is to achieve harm minimisation through a balance of supply control measures (controlling or limiting the supply of drugs) and demand reduction (reducing individual demand for drugs). The term harm reduction is used in the Prison Drug Strategy to refer to programs that address overdose, safer injecting, and transmission risk. The focus of harm reduction is typically on the physiological effects of drug use and the identification of high-risk behaviours for HIV, hepatitis, tuberculosis and other diseases, with the primary aim being to reduce the risks to health associated with drug use.

Support for the provision of harm reduction programs in prisons comes from the World Health Organisation (WHO) (1993). According to the WHO, the same health prevention and treatment measures that are provided to members of the wider

community should also be available within prisons (the Principle of Equivalence). This principle has, for example, underpinned the introduction of a needle exchange program as part of a harm reduction measure in Hindelbank, a Swiss prison for women (Nelles, Fuhrer, Hirsbrunner & Harding, 1998). On entry into the prison, all inmates were provided with a dummy syringe, which could subsequently be exchanged in prison. Automatic dispensers were installed in accessible wings of the prison outside of general view, with clean injecting equipment only being dispensed in exchange for a used syringe. The Swiss programme also included lectures and group sessions, socio-medical counselling, and the distribution of condoms. An independent evaluation of the program indicated that staff concerns about operational or security problems associated with syringe distribution were unjustified, and that the sharing of used syringes virtually disappeared. Furthermore, while at 3 and 6 month follow-up there was no significant reduction in the proportion of inmates using heroin and cocaine, at the end of the one-year project the proportion of users had decreased.

Similar needle exchange schemes have been implemented in both male and female prisons in Germany (Stoever, 2002). While some of these programs use anonymous 'slot machines' to exchange equipment, others involve face-to-face contact with the assurance that prisoner confidentiality will be maintained. The exchange is typically offered in conjunction with individual counselling and information meetings and papers on HIV/AIDS and hepatitis. The only prisoners generally excluded from these programs are those participating in methadone maintenance or some other form of substitute prescribing.

Whilst programs designed to reduce the physical harms associated with substance use are unlikely *per se* to reduce the risk of drug- or alcohol-related recidivism, they do offer an important first step towards rehabilitation, at least for some offenders. Harm reduction programs may be particularly appropriate as either (a) secondary prevention or (b) early intervention programs for offenders who are at an early stage in their substance use but who are not necessarily seeking to change their use. Day, Howells and Rickwood (2003, p.154) have argued that "Many [young] offenders are often either not ready to give up drug use or do not have the skills and environmental support to enable them to do so. It is important to recognise

this and provide them with the skills to keep themselves alive and as harm-free as possible until they can make the choice to give up drugs”.

Although professionals often deliver harm reduction programs, there has been a growth in the use of peer educators in program delivery, given that a principal aim of these programs is the spread of harm reduction information about infective diseases and substance use through the offenders’ social networks. In an evaluation of a peer education program delivered across juvenile justice in Victoria, Miller (date unknown) found that young people who attended the peer-education programs were more likely to seek professional help, with nearly all participants reporting that they had informally educated other people, with significant numbers (83%) reporting still doing this at 4 week follow up.

Whilst there is only limited empirical evidence linking attendance at a harm reduction programs with measurable outcomes such as increased motivation for change, on balance, it does appear that this type of program can play a positive role as part of a broader treatment strategy.

Psycho-Educational Programs

Brief psycho-educational programs can be placed within the context of harm minimisation, given that aim of such programs is to reduce the demand for drugs. This type of program is perhaps the most common, and the least intensive, of all programs currently delivered in the prison environment (Incorvaia & Baldwin, 1997). The programs offer prisoners an opportunity to discuss the benefits of drug and/or alcohol treatment and behaviour change, with principle aim being to increase a prisoner’s motivation to enter treatment. Programs typically involve the delivery of information and education in a small group format, and vary from single sessions through to brief structured programs. Motivational interviewing (Miller, 1991) is one example of a brief treatment approach that is used to increase problem recognition and the probability of treatment entry. It generally involves some discussion regarding the arguments for and against the individual changing their substance use behaviour (decisional balance), feedback about the risks and benefits of continued substance use, and a description of the available treatment options. Research (e.g., Brown & Miller,

1993) has shown that individuals who receive motivational interviewing prior to treatment entry participate more fully in the treatment program.

Alcohol education programs (AEPs), such as the Ending Offending program (Baldwin, 1991) that was developed in community settings in the UK, have been successfully implemented in Australian correctional settings in the Northern Territory, New South Wales and South Australia (Baldwin, Soares, Watts, Colyer, Maxwell, Deacon & Dwyer, 1996). The Australian adaptation of the Ending Offending alcohol education program retains the 6 week, 12 hour, small group format used in the UK, but with some modifications made to the original materials to enhance cultural responsiveness, particularly with Aboriginal offenders (Baldwin et al., 1996). Another example of an alcohol education program is that offered by the Ministry of Justice in Western Australia (Papandreou, 1999). This program consists of four sections: 1) knowledge of alcohol and its contribution to offending; 2) information on alcohol, the law and problem drinking, with a focus on alcohol related offences; 3) identifying problem drinking; and 4) education about the physical and psycho-social effects of alcohol.

An evaluation of the Ending Offending AEP delivered in the Northern Territory suggests that it has a positive impact on both alcohol use and offending behaviour (Crundall & Deacon, 1997). The aim of the program is to minimise the harm related to alcohol use by teaching people how to drink sensibly, and to highlight the connection between drinking and committing crime. The program is delivered through a structured course, involving verbal and video presentations, small group discussions and role-plays. The course primarily targets the relationship between drinking behaviour and imprisonment and how drinking can be altered. While outcome measures used in the evaluation limit the conclusions that can be drawn from the results, offenders who had completed the program (87% of whom were Aboriginal) were significantly more likely than non-program participants to report (a) having reduced their level of alcohol consumption, (b) their engagement in violent or disruptive behaviour, and (c) having been in less trouble with the law.

Some practitioners (e.g. Wexler et al., 1991) have argued that all prisoners can benefit from drug education irrespective of drug use history, although there

appears to be little empirical evidence to support such a claim. It would appear (at least as applied to alcohol use), that small, personally relevant educational groups that target those individuals at risk of binge-drinking and other high risk behaviours are more effective than sessions that simply provide information and focus on the dangers of alcohol consumption alone (Freeman, 2001). While these findings may not extrapolate to offenders, in the absence of evidence to the contrary, some caution is needed before committing to the universal delivery of harm minimisation programs.

A meta-analysis of the effectiveness of prison based programs on recidivism by Pearson and Lipton (1999) reviewed the effectiveness of 12-step programs¹ (e.g., Alcoholics Anonymous or Narcotics Anonymous). This review concluded that while evaluations of this type of program generally lack good methodological quality, the findings tend to support the view that such programs are more effective in preventing relapses than actually reducing recidivism. It seems that 12-step programs are most effective when used, not as the primary treatment modality, but in conjunction with CBT and/or educational programs.

Although the Pearson and Lipton (1999) review suggested that drug education is unlikely to be effective (in reducing recidivism) as a stand-alone treatment for imprisoned substance users, this finding does not negate the utility of such programs. Education is an important aspect of treatment. It forms a standard component in the majority of treatment programs, and is commonly used as part of a multi-modal treatment package. However, as non-residential treatment programs become more intensive, there is greater emphasis on therapeutic change and less emphasis on increasing knowledge. The more intensive programs at this level typically combine drug education with psychological (often cognitive-behavioural) treatment methods.

Non-Residential Treatment Programs

Correctional Services of Canada offer a non-residential High Intensity Substance Abuse Program (HISAP) aimed at offenders with severe substance use

¹ Twelve-step programs typically view substance use as an illness, follow themes of spirituality, and encourage individuals to discuss their problems with peers in order to help each other. General guidance is provided by facilitators through 12 specific, graduated steps progressing from “dealing with denial to sustaining a healthy, responsible and abstinent lifestyle” (p. 405).

problems (Eno, Long, Blanchette, Hansen & Dine, 2001). This program, which is based on a social learning model, is relatively intensive in that it consists of 100 two-hour sessions (8 sessions per week over a 4-5 month period). The program involves three distinct phases of treatment: intensive, regular maintenance sessions in preparation for release, community programming.

Another example of a non-residential treatment program is the Kowhai Unit Program in New Zealand (Huriwai, 2002). This program utilises a cognitive behavioural/relapse prevention program, with an initial phase addressing motivation to change, a second phase involving the construction of offence and relapse chains, and a third phase using a range of modules devoted to key components of the offence chain such as mood management, relationships and communication skills, and improving lifestyle balance. The fourth phase focuses on post-release lifestyle planning, progressing to the final phase, which follows release from prison, entailing re-integrative support in the community.

The Lifeline Programme implemented by the Scottish Prison Service (2003) is an example of a detailed, well-designed, evidence-based treatment for substance misusing offenders. Lifeline is a short relapse prevention program based on a cognitive behavioural model, with an emphasis on lifestyle change and self-management. The program is completed over four weeks, with ten half-day sessions per week. To participate in the programme, offenders should meet the following criteria:

1. Male young offender, female offender or short-term adult male offender (as these are the target groups for whom the programme has been designed).
2. Have a release date of less than 12 months following completion of the programme.
3. Recent history of problematic drug use (have used drugs within the previous 3 months, either in prison or in the community, with the use having a detrimental effect on social functioning, quality of life, relationships, health, ability to work, or progression through the correctional system). The program is most suited to 'heavy' users of 'heavy' drugs such as opiates or benzodiazepines, however there are no restrictions on drug types or frequency

of use. It is unsuitable for prisoners who have used drugs in prison but have remained abstinent for some time.

4. Motivated to be drug-free and participate fully in the programme (assessed primarily on the basis of information provided at interview, in conjunction with details collected from other sources).
5. Basic literacy skills (based on ability to read, understand and sign the initial consent form and to complete the psychometric questionnaires).
6. Cognitive ability to complete group work tasks and assignments.

One of the few non-residential programs for women described in the literature is the Nevada Women's Correctional Centre (USA) substance use education class. This is an intensive 10-week, 40-hour course, offered three times per year to groups of up to 25 women per session. (Sanders, McNeill, Rienzi & DeLouth, 1997). The program was developed in response to survey results indicating a strong need and desire for substance use education and treatment among the prison population. Classes are coordinated by a staff psychologist and taught by community volunteers. Priority for participation is given to those inmates first due for release to the community. The course focuses on the life threatening and damaging impacts of alcohol and other drug use, including such topics as self-esteem, foetal alcohol syndrome, triggers of addiction, domestic violence, childhood sexual and physical abuse, HIV awareness, family dynamics of addiction, anger management, spirituality and recovery, recovery skills, and values. Participants attend 40 classroom hours, complete required reading and homework, watch 20 assigned educational videos and need to obtain 80% on a final exam. Participants receive credit for completing of the program, and the authors argue that all inmates who take part benefit, regardless of their reasons for attendance.

A number of studies have examined the outcomes of non-residential programs for offenders. Generally, the early studies have reported lower re-conviction rates for prisoners who were offered brief behavioural or cognitive-behavioural programs (Peters & May, 1992; Platt, Perry & Metzger, 1980). These findings have been supported by more recent research. For example, Delnef (2001) has reported that the Canadian Offender Substance Abuse Pre-release Program (OSAPP) has a positive effect on post-release re-admission rates, particularly for offenders with high level substance use severity and low level risk. A recent

evaluation of Canadian Correctional Services Substance Abuse Programs (T3 Associates, 1999, cited by Delnef, 2001) examined the impact of the OSAPP program on 2,731 offender participants, of whom 2,432 completed the program. A number of different outcome measures were used in this study, including client self-report, granting of release, and post-release outcomes assessed through official recidivism records. Offenders who had been released for a minimum of 12 months were included in the follow-up sample ($N = 1,216$), and classified as program completers or dropouts. OSAPP completers were found to have a lower proportion of reconviction (15.1%) as compared to dropouts (19.7%). Moreover, OSAPP participants who attended other substance abuse programs in the community (i.e., Alcoholics and Narcotics Anonymous) had superior outcomes compared to those who did not participate in such programs.

The Pearson and Lipton (1999) meta-analysis revealed varying degrees of treatment effectiveness for the different types of non-residential treatment programs examined. For example, all seven studies included in the analysis that assessed group counselling outcomes drew the conclusion that this particular type of program did not lead to statistically significant reductions in recidivism. By contrast, studies assessing the effectiveness of cognitive behavioural therapy² (CBT) produced more encouraging results. Where CBT had been used as a secondary or tertiary component in the treatment regime³ (i.e., it was not the primary treatment modality), the mean unweighted effect size ($r = .08$) was “promising enough to merit future research (Person & Lipton, 1999, p.403).

In the UK, the provision of services to substance misusing offenders in prison is organised through the CARAT system (Counselling, Assessment, Referral, Advice and Throughcare; National Treatment Agency, 2002). This is an arrangement with non-statutory specialist substance use service providers to provide treatment and support for substance users while they are in prison, through liaison with prison

² CBT generally involves teaching “self-reinforcement, self-instruction, self-rehearsal, role-taking, self-control and problem solving as ways of changing pro-criminal cognitions and expectations” (Pearson & Lipton, 1999, p.403), methods that are commonly employed in non-residential substance use treatment programs.

³ Where programs had more than two components, each component was hierarchically coded in terms of level of importance to the overall program where primary represented the most important treatment component.

healthcare and by acting as an interface between prison and community services. CARAT services are commissioned by the prison service and offer:

- Initial assessment on first reception
- Health liaison with community agencies at the time of reception
- Specialist input into pre-sentence reports, bail applications & assessments for home detention curfews
- Post-detoxification assessment and support
- Specialist input into sentence planning
- Counselling aimed at addressing drug problems (individual and group)
- Support and advice on a range of drug, welfare, social and legal issues, including harm minimisation
- Assessment for in-prison rehabilitation programmes
- Assessment for post-prison rehabilitation programmes/drug services
- Pre-release training
- Health liaison with community agencies on a prisoner's release
- Liaison with and referral to community agencies to enable effective resettlement

Prison- Addressing Substance Related Offending (P-ASRO) is a group intervention designed for male prisoners, which deals primarily with increasing self-control involving four core components (McMurran & Priestley, 2003). The first component is a motivational enhancement module. The remaining components involve bringing substance use back into conscious processing, so that changes can be sustained (the personal scientist); the identification of situations where there is a risk of relapse to substance use and teaching coping strategies to prevent that relapse (relapse prevention), and encouraging broader lifestyle changes so that improvements can be maintained (lifestyle modification). P-ASRO aims to address criminogenic risk factors in the following ways (see table 2.1):

Table 2.1. How P-ASRO addresses dynamic risk factors (McMurrin & Priestley, 2003, p. 14)

<i>DYNAMIC RISK FACTORS</i>	<i>ELEMENT USED</i>	<i>SESSION ADDRESSED</i>
Dependence on alcohol & drugs	Practical exercises, role play, assignments, presentations	Throughout the programme
Poor motivation to tackle drug and/or alcohol use	Practical exercises, role play, "Things I value" assignment, goal setting	Sessions 2-4
Difficulty with self management & self control	Practical exercise e.g. "Behaviour analysis", self monitoring charts	Session 5
Difficulty in recognising triggers and high risk situations likely to lead to relapses	Practical exercises e.g. "Triggers experiment", "Risk Jungle", assignments, self monitoring	Sessions 6, 11, 12
Difficulty with management of stress, anger, conflict, anxiety & depression	Relaxation exercises, practical exercise e.g. "A day in the life", "STOP THINK!" assignments	Sessions 7, 8, 12, 14, 15
Outcome expectancies for substance use	Practical exercise e.g. "Futurama"	Session 9, reinforced during module 4
Problem Solving deficits	Practical exercise e.g. "STOP THINK", the "You Game"	Session 13, 15
Strong ties & identification with anti-social/criminal peers	Practical exercise e.g. "The Web", "Mr/Ms Perfect"	Sessions 16, 17
Weak social ties and identification with pro-social/non-criminal model	Presentation e.g. promotional, practical exercise, e.g. "New activities"	Sessions 18, 19
Anti-social attitudes, beliefs & rationalizations	Assignments e.g. "New activities experiment"	Sessions 18, 19
Literacy, numeracy and employment	Creative opportunity e.g. job seeking	Sessions 18, 19

The U.S. Federal Bureau of Prisons (2000) conducted a three-year follow-up study of drug abuse treatment programmes (DAPs) in what is known as the TRIAD (Treating Inmates' Addiction to Drugs) evaluation. DAPs are designed for both male and female offenders with moderate to severe substance use problems. DAPs involved three stages of treatment: up to twelve months of unit based residential treatment in prison, followed by up to twelve months transitional treatment in the general prison population, and further residential treatment in a community halfway house after release. Tracking over 2000 graduates of DAPs, and a control sample of untreated ex-prisoners with similar substance use histories, the study found that 3 years following release, 44.3% of treated men had been arrested or had their post-release supervision revoked, compared with 52.5% of the untreated men. While recidivism rates were also lower for treated women compared with untreated women, that difference was not statistically significant. Treatment effects were also observed in terms of relapse into drug or alcohol use: 49.9% of treated males and 35% of treated females were likely to relapse, compared with 58.5% of untreated men and 42.6% of untreated women. The

rigorous methodology employed in this evaluation makes these results even more encouraging.

Methadone Maintenance

Methadone maintenance treatment is another form of non-residential treatment that is likely to have positive effects on recidivism. Johnson (2001) compared the post-release outcomes for Canadian offenders who had participated in Phase 1 of an institutional National Methadone Maintenance Treatment (MMT) program (N = 187), with other heroin-addicted offenders who had not participated in MMT (N = 112). Participation in Phase 1 of this program requires that the offender has recently participated in community MMT, and thus the prison program was designed to be a continuation of community treatment. In this study, measures of outcome included readmission to federal custody, type of revocation, and re-offending. At approximately 12 months after release, 41% of the MMT group had been re-admitted, compared to 58% of the Non-MMT group - a statistically significant difference. When reasons for revoking conditional release were considered, the Non-MMT group were significantly more likely to have a violation of an abstinence condition for alcohol use (9% versus 2%). Twenty four percent of the Non-MMT group had re-offended compared with 18% of the MMT group. This difference was not statistically significant. Thus, it is likely that this program decreased rates of recidivism by increasing adherence to other release conditions.

A meta-analysis by Marsch (1998) identified 24 studies that have looked at the effect of methadone maintenance treatment on offending. Marsch found that MMT has significant effects in reducing not only illicit opiate use and HIV risk behaviours, but also drug and property-related criminal behaviours. The effectiveness of MMT is most apparent in reducing drug-related criminal behaviours, with a significant overall large effect size of $r = 0.70$ (unweighted). Knowledge of effect size enables the prediction of probable outcomes as a result of treatment. Given a sample of opiate-dependent individuals in MMT, approximately 85% may be expected to decrease their drug-related criminal behaviours, 61% to decrease their drug-and-property-related criminal behaviours, and 58% to decrease their drug-and-non-drug-related criminal behaviours. The potential existence of unpublished, non-significant findings that

could negate the demonstrated effect of MMT on reducing criminal behaviours was considered in the meta-analysis, “fail safe N” (Marsch, 1998, p. 526). Calculations indicated that 1,697 studies demonstrating non-significant results would be needed to reverse the conclusion of the statistically significant finding.

The results of the meta-analysis (Marsch, 1998) indicate that MMT is most effective in reducing drug-related criminal behaviours, although a substantial effect on drug-and-property-related criminal behaviours is also evident. It is suggested by Marsch that this is an indirect result of the intervention’s direct effect in reducing illicit opiate use, such that as substance use decreases so to do criminal behaviours related to procuring funds to support that substance use. The author further suggests that treatment effects may be restricted to those crimes that are associated with substance use, and that opiate-dependent offenders may engage in certain criminal behaviours not directly related to substance use.

Such findings are consistent with previous research showing that methadone treatment greatly reduces crimes associated with heroin addiction and leads to increased social productivity (Magura, Casriel, Goldsmith & Lipton, 1987). Joe, Brown and Simpson (1995) have also suggested that those clients reporting high levels of psychological problems were twice as likely to attend methadone program counselling sessions, than those with no psychological problems. It may also be useful for poly-substance users (Strain, Stitzer & Liebson, 1994), and effectiveness may be further enhanced when substitution treatment occurs in conjunction with counselling (Kraft, Rothbard & Hadley, 1997).

Unit Based Residential Treatment

Unit Based Residential Treatment is the most intensive form of intervention offered in prisons (Wexler, Falkin & Lipton, 1990). This term is often used to refer to therapeutic community programs, but may also be used to refer to drug-free treatment units and boot camps. Therapeutic communities typically offer intensive, long term, self-help, highly structured, residential treatment for chronic substance users. Prison based therapeutic communities are often adaptations of those developed in community

settings and vary according to the extent to which they adhere to therapeutic community treatment philosophies. Pearson and Lipton (1999) argue that a defining feature of a therapeutic community is that the treatment problem to be addressed is the person, not the drug. Effective treatment is thought to be associated with a commitment to the positive values of the community, social values such as the work ethic, social productivity and communal responsibility, and personal values such as honesty, self-reliance, and responsibility to oneself and significant others. Group discussions and meetings are an important part of the treatment, and peers are used to provide positive persuasion to change behaviour. Bouffard, Taxman and Silverman (2003) have argued that “the traditional therapeutic community is implemented in a separate living environment and focuses on developing prosocial values by promoting a positive peer culture. The treatment community itself is seen as the primary agent of change in the TC model. Within the treatment community there is frequently a reliance on structured systems of interaction... ..since antisocial peer associations and influences are often linked to the development of substance use problems, the positive peer culture developed among the community itself is viewed as an integral part of the re-socialization of appropriate values and behaviours” (p.150). Bouffard et al. (2003) present a methodology from which the extent to which prison therapeutic communities adhere to these ideas might be assessed.

In the USA, many communities operate on behavioural principles, using a system of punishment and reward (Incorvaia & Baldwin, 1997). For example, they are organised hierarchically, with incentives to earn privileges, and improved accommodation. This type of unit is sometimes referred to as a drug-free unit. Wexler (1995) reports that prison-based therapeutic communities tend to be shorter (6-12 months) in duration and that community-based programs are more likely to emphasise self-help and relapse prevention methods. In their recent review of correctional substance use programs, Pearson and Lipton (1999) also included boot camps as a form of residential treatment offered in US prisons. Boot camps are based on a military model, using shock approaches, military drills, confrontations and disciplining by drill instructors.

Some of the strongest evidence for program effectiveness comes from evaluations of intensive residential programs, such as therapeutic communities (TC).

In the USA, the first large scale federally funded evaluation of prison drug treatment (the Stay 'n Out prison therapeutic community) reported a significant reduction in recidivism rates for the program contrasted with several comparison groups. In 1991, these findings were reinforced by a 5 year evaluation of a different therapeutic community (the Amity TC) (see Graham & Wexler, 1997). The US Department of Justice reports that for inmates who completed a prison residential treatment program, only 3.3% were likely to be arrested in the first six months after release, compared with 12.1% who did not receive treatment. Similarly, among those who received treatment, 20.5% were likely to use drugs in the first six months after release compared with 36.7% without treatment (Federal Bureau of Prisons, 1999). Wexler, Falkin and Lipton (1990) reported that the percentage of therapeutic community males rearrested (27%) was significantly lower than for the no-treatment control (41%), and comparison treatment groups (35% milieu group, 40% counselling group).

Researchers have generally suggested that therapeutic communities consistently achieve reductions in recidivism (Wexler, DeLeon, Thomas, Kressel & Peters, 1999; Hiller, Knight & Simpson, 1999). Pearson and Lipton (1999) concluded that therapeutic communities demonstrate sufficient effectiveness in reducing both substance use and recidivism, to be important in programming and policy-making decisions.

There are mixed findings about other forms of prison residential treatment. Shewan, MacPherson, Reid and Davies (1996) evaluated a residential prison reduction program, or drug free unit, reporting that those who completed the program used fewer drugs than those who did not. Pearson and Lipton (1999) reviewed existing research on the effectiveness of boot camps, finding that they are largely ineffective in reducing either substance use or recidivism when compared to no-treatment comparison groups. They reported that two studies have actually found higher rates of post-intervention recidivism in boot camp subjects relative to a comparison group.

Prison Transition

For all of the programs described above, the issue of through-care and links between prison based and community services is particularly important. *Transitional Programs*, including both pre-release programs and half-way houses, are used to help reintegrate the offender back into the community.

A published study by Hiller et al. (1999) examined the impact of residential aftercare on recidivism following completion of a prison-based therapeutic community treatment. A group of 293 treated prisoners were compared with a matched group of 103 prisoners who did not receive the residential aftercare treatment. Hiller et al. (1999) reported that the prison based treatment both lowered the risk of re-offending after release and prolonged the length of time until re-arrest. They reported that reductions in recidivism were increased when treatment was supplemented with residential community-based aftercare. They suggest that the first 90 days after release are likely to be a particularly dangerous time for relapse and considered that aftercare facilities could significantly reduce this risk. Hiller and colleagues conclude that correctional treatment should follow a through-care model linking services from prisons through to the community.

Community Based Programs

Community non-residential programs or outpatient treatment involve a wide range of treatment protocols, ranging from professionally delivered psychotherapy to informal peer discussions for those either unable or unwilling to enter other forms of treatment. Counselling services vary considerably and include individual, group or family counselling, peer group support, vocational therapy and cognitive therapy. Pearson and Lipton (1999) note that there are few clear descriptions of group-counselling programs for offenders with substance use problems.

The only community based harm reduction program for offenders we have identified in this review is the ARRIVE program (AIDS Risk Reduction for IV Drug Users), developed for parolees with a history of drug injection and recently released from prison (Wexler, Magura, Beardsley & Joseph, 1994). The program takes a social learning approach to prevention, emphasising self-help, individual responsibility, and therapeutic community principles such as credible role models and

community building. One-year follow-up showed that participation in the ARRIVE program significantly decreased certain sexual and drug-related risk behaviours and improved community adjustment.

Community health education programs have also been developed to target the reduction of harms associated with volatile substance use by Aboriginal offenders. These emphasise a number of alternative behaviours or methods for use (Sandover, Houghton & O'Donoghue, 1997).

An example of a more typical community program is the Community Correctional Brief Treatment, Relapse Prevention and Maintenance program (or 'Choices') offered by Correctional Services in Canada (Delnef, 2001). The Choices program targets offenders with low-low/moderate substance use problems on conditional release in the community, and consists of an intensive phase of treatment (one week, full time or two weeks, half time), followed by a less intensive maintenance phase (12 weeks, one day per week).

In Australia, external service (NGO) providers often provide these programs. It is likely that many of these agencies work primarily from within a health and problem reduction philosophy of care, and consequently place less emphasis on criminogenic targets of change than service providers working from within correctional organisations. The role of substance use as a criminogenic need is discussed later in this report.

Community Education Programs

Evaluations of community-based programs, even when designed for offenders, usually measure (only) reductions in substance use as the primary outcome measure. One of the few studies that has looked at the impact of community education programs in terms of recidivism was a UK comparison between two different types of alcohol education program (AEP); a behavioural/skills based AEP which focuses on the target behaviours of drinking and offending and assists clients to learn new skills in reduced drinking or abstinence, and a counselling/talk-based AEP which focussed on insight-oriented, self-directed groups discussion. Both programs were offered to

client-offenders aged 17-29 who participated in groups of 5-10 people, for 6 x 2-hour teaching sessions. Outcome evaluation at 6, 12 and 18 months post-completion suggested that only those client-offenders who completed the behavioural AEP achieved reliable reductions in both drinking and offending behaviour (Baldwin, 1991). Limited support has also been found for an information-based AEP (which is restricted to the provision of information and therefore does not focus specifically on offending behaviour). In comparison to no-treatment-controls, some offenders who completed the information-based AEP had modified their drinking behaviour, although offending behaviours had generally not reduced.

Community Non-Residential Treatment

In the UK, the National Health Service has recently published a review of Care Planned Counselling for substance users (NHS, 2002). Care planned counselling encompasses all formal structured approaches that include an assessment, treatment planning, goals and review components. They distinguish this model of care from those that provide advice and information, drop-in support and informal key-working. Duration of counselling interventions varies according to the counselling model employed, e.g. six week duration for brief interventions, mid-term for cognitive-behavioural and motivational interviewing.

The ASRO (Addressing Substance Related Offending) program implemented in the UK is an offending behaviour program for substance-misusing offenders, based on cognitive-behavioural principles and designed to be delivered in the group work format (McMurrin & Priestley, 2001). The program is normally delivered by two members of staff, and consists of 20 two-hour sessions designed to enhance motivation to change, teach skills of self-control and relapse prevention and encourage lifestyle modification in ways that will reduce risk of relapse to substance use and further offending.

COVAID (Control Of Violence for Angry Impulsive Drinkers) is a structured, cognitive-behavioural treatment programme, designed as an individual intervention for offenders in the community who therefore have unrestricted access to alcohol (McMurrin & Cusens, 2003). COVAID targets aggression and violence by addressing

the mediators of anger, impulsivity and drinking, and is based upon a developmental risk factor model of alcohol-related violence (McMurran, 1996). Evaluation of programme effectiveness is as yet limited to the reporting of individual case studies, comparing 6 men who had completed COVAID with 10 who had been referred but did not complete the programme. For aggressive and violent offending, the odds ratio for re-conviction is 2.14, meaning that without COVAID treatment the chances are two times higher that an offender will be reconvicted compared with those who participate in COVAID. Of course, with such a small number of participants, the confidence interval is extremely wide.

A recent outcome evaluation of prison-based and community programming in Canadian Corrections has highlighted the importance of sustained program exposure in changing offenders' behaviour and reducing recidivism, suggesting that "community programming is not just desirable, but essential" (Porporino, Robinson, Millson & Weekes, 2002, p.1071) The latter authors found that reductions in recidivism for offenders who had completed a prison based non-residential program (OSAPP) *and* substance use treatment in the community (such as Choices or Alcoholics or Narcotics Anonymous [AA/NA]) ranged from 22 to 48%.

Another recent study evaluated the effectiveness of alcohol treatment programs on driving-under-the-influence (DUI) recidivism for both first, second and third-time offenders in the Californian Criminal Justice System (Deyoung, 1997). In this jurisdiction, first-time offender programs are generally 3 months in duration and consist of at least 10 hours education, 10 hours counselling, and a further 10 hours of education/counselling with regular face-to-face interviews with program staff. Second-time offenders may be sentenced to attend an 18-month SB38 program (named after the relevant legislation), which require at least 12 hours of education, 52 hours of counselling and bi-weekly face-to-face interviews. Treatment for offenders convicted of DUI for a third or subsequent time has previously consisted of repeating SB38 programs, however in more recent years 30-month programs have been initiated consisting of at least 18 hours education, 117 hours counselling, 120-300 hours of community service and regular face-to-face interviews.

For both first and second-time offenders attending these programs, the lowest levels of recidivism were found among those offenders who participated in the alcohol treatment program and who also received some form of license restriction, compared to offenders who were either imprisoned and/or had their license restricted or suspended. As such, a combination of education and counselling had a significant positive effect on re-offending. With regard to third-time offenders, results indicated that 30-month treatment programs were more effective in reducing DUI recidivism than license suspension, however there was no evidence that the 30-month program was any more effective in reducing recidivism than the shorter (and therefore cheaper) SB38 programs. This finding is consistent with a meta-analytic review showing that neither the duration of an intervention nor the number of hours it contains has a significant effect on DUI recidivism (Wells-Parker & Bangert-Drowns, 1995).

In this meta-analysis of remedial interventions for drink-driving offenders, Wells-Parker and Bangert-Drowns (1995) suggest an average reduction on DUI recidivism of 7-9%, compared to 'no remediation' groups. Analyses suggest that the largest effects on recidivism were found for those programs incorporating a combination of modalities, particularly those including education, psychotherapy/counselling and some follow-up such as contact probation. In the absence of any attempt to match individual needs to treatment, it appears that those treatment modalities with 'something for everyone' are the most effective interventions overall.

Community Residential Treatment

Studies of therapeutic community programs conducted in community settings have also shown that substance use and criminality decline after treatment (e.g., Brook & Whitehead, 1980). Melnick, De Leon, Thomas, Kressel and Wexler (2001) in their evaluation of the Amity prison therapeutic community have described this program as consisting of three treatment phases: orientation (2-3 months); primary treatment phase (5-6 months; incorporating work, encounter groups and individual therapy; focussing on the acceptance of therapy, taking responsibility for oneself, self-awareness, respect for authority, and self-esteem); and a re-entry phase

lasting up to 3 months. Graduates of the prison TC then enter a community-based aftercare TC on a voluntary basis.

The evaluation of this program compared 290 no-treatment controls with 110 clients for whom 12-month follow-up data and 3-month client and staff ratings were available. Statistically significant differences on the major outcome measures were found between non-completers, completers, and completers who volunteered to enter aftercare. Path analysis revealed a significant path between motivation and program participation and entry into aftercare, and between aftercare entry and lower 12-month recidivism rates. Criminal history and substance use severity had a direct effect only on the motivation-participation interaction, suggesting that the influence of these factors on relapse and/or recidivism is, at least partly, mediated by motivation. As such, the treatment process itself is crucial to continuance in aftercare and the enhancement of internal motivation and inmate participation in order to continue in community treatment is a necessary component of prison-based treatment programs. Again, these findings suggest that any coherent response to the problems raised by substance misusing offenders will require an integrated approach. Given that approximately two thirds of relapses occur within the first three months following treatment (Tucker, Donovan & Marlatt, 1999), such findings are not surprising.

Summary

This review of the published literature has illustrated the range of interventions that are offered to offender with histories of substance use. These range in intensity from brief harm reduction and health education programs, to psycho-educational programs, through to therapeutic treatment and residential programs. The review suggests that all of these levels are likely to be important parts of any co-ordinated response to meeting the needs of substance using offender, with behavioural and multi-modal programs likely to hold the most promise in terms of reducing crime. The review further suggests that all of these programs are likely to work best when supported by methadone maintenance program and by a coherent throughcare system.

In summary, there is clearly a growing evidence base to support the suggestion that many programs will have not only have positive effects in reducing levels of substance use, but also in reducing recidivism.

Implications of the Literature Review for Service Mix of Substance Use Programs

The focus of this review has been on specific programs, treatment and interventions that have been used with substance misusing offenders, rather than on the social or administrative context in which interventions take place. That is not to say that such contexts are not relevant or important. It is widely recognised, for example, that an effective case management system is critical to the effective delivery of rehabilitation interventions. Case management provides the assessment and case planning components; it sets the objectives, tasks, activities, and forms the basis for planning, sequencing or scheduling of any required tasks or interventions. Thus whilst the published literature identifies some of the main components of drug and alcohol service delivery that are likely to be effective, it does not offer specific guidance about how services should be co-ordinated between institutions and settings, or between different intensity or types of program.

Whilst there is a developing body of empirical research supporting the effectiveness of offender treatment programs, there have been surprisingly few reviews of the area and, to our knowledge, only one meta-analytic review (Pearson & Lipton, 1999). Furthermore, only a relatively small number of empirical studies met the criteria for inclusion in this meta-analysis which included only 26 studies (of which six related to boot camp programs). Only two studies were included that evaluated the effectiveness of substance use education (the most commonly offered type of program) on offending. Despite this, the available evidence suggests that there is significant cause for optimism in the ability of programs to impact positively on recidivism. It is also possible, on the basis of the literature, to comment on the types of intervention that are most likely to be effective. Many of the programs used as illustrations in this review (such as those developed in Canada and the UK) have only recently been developed. These programs adopt an offending-focus and seek to

directly target criminogenic need. Whilst the evidence on the impact of these programs is only beginning to emerge, it seems likely that these types of program will have the greatest effect on reducing re-offending.

The published literature contains few studies which comment upon the effectiveness of remand and reception programs and processes, programs for non-substance misusing offenders convicted of drug related offences (e.g., trafficking), and relatively few descriptions of programs adapted to meet the specific needs of Indigenous, female, disabled, and younger offenders. Few of the studies identified also describe the characteristics of their sample in terms of risk of re-offending or extent to which substance use for the individual should be considered criminogenic. These issues are discussed later in this report.

In our reading of the literature, it seems clear that all four levels of the US Bureau of Prisons are important. Having a broad range of programs and services would be consistent with the different causes and patterns of substance use in offenders. Generally, it would seem that the greater the intensity of the program, the greater the effectiveness of the program, although this issue is discussed later in this report. The strongest evidence of effectiveness comes from intensive treatment programs, and from methadone substitution programs. Whilst there is relatively little evidence to suggest that prison education programs by themselves will impact directly on recidivism, they are clearly important in terms of harm reduction and potentially in motivating offenders to attend treatment. There is little evidence from which to base any comments on how exposure to harm reduction programs, psycho-educational programs and treatment programs might combine to reduce substance use and offending, although the finding that multi-modal treatments are particularly effective, suggests that a combination of programs could work well.

Although drug and alcohol programs have generally been included together in this review under the discussion of substance use programs, it is important to note that there are important differences between the treatment of those who only use alcohol and those who use other substances. Where alcohol is concerned, the identified relationship is primarily with violent crime (although the economic effects of heavy drinking and consequent acquisitive offending are not well investigated).

Where illicit drugs are concerned, the identified relationship is primarily with acquisitive offending in users, although there is an association with violence the commercial aspects of the drug trade are taken into account. The fact that alcohol is legally available makes a considerable difference in terms of treatment. For example, criminal justice professionals need not pursue an abstinence goal, lapses and relapse can be openly investigated as part of treatment, and treatments need to address living in a 'wet' culture where alcohol plays an important social role.

Non-residential treatment programs, particularly those based on behavioural (and probably cognitive-behavioural) methods, do appear to impact positively on recidivism, as do pharmacological approaches such as methadone maintenance. 12-step programs, such as Narcotics Anonymous, appear to be most useful as an adjunct to more formal treatment. Alcohol education and drink-driving programs also appear to be promising.

The strongest evidence for program effectiveness comes from residential programs, particularly those described as therapeutic communities. A summary of the effect sizes found for different types of programs from the Pearson and Lipton (1999) meta-analysis can be found in Appendix A. For these programs, and potentially, all other prison-based programs, effective through-care into the community will further improve outcomes. Generally, community based care is likely to be more effective when it follows a structured and treatment-focussed format, rather than general support and counselling.

An interesting feature of the published research in this area is the recent focus on the provision of offender substance use programs that are based on addressing substance use as a criminogenic need. Programs have been developed in Canada, New Zealand and the UK from within an offender rehabilitation framework. Whilst these programs have not been running sufficiently long for research reporting on their impact on recidivism to be published, it is likely that programs targeting criminogenic need will be more successful in reducing re-offending. This issue is discussed further in the next section of this report.

The main research reviewed in this report is summarised in Table 2.2 below:

Table 2.2: Summary of literature reviewed for this project

Location	Program	Example program/research	Aim	Method	Summary of Evidence-basis
Remand		Brooke et al. (1998)			No outcome studies identified
Reception	Screening for D&A	-			No outcome studies identified
	Medical/health treatment and withdrawal	-			No outcome studies identified
	Harm minimisation			Education	No outcome studies identified
Prison based programs	Harm minimisation	Needle exchange program (Nelles, Fuhrer, Hirsbrunner & Harding, 1998)	Reduce drug related harm esp. spread of infectious diseases.	Syringe exchange plus information/counselling	Leads to significant reduction in sharing of syringes & therefore the likelihood of disease transmission.
	Intensive non-residential treatment programs	CANADA: High intensity substance use program (HISAP; Eno et al, 2001) NEW ZEALAND: Kowhai Unit Program (Huriwai, 2002)	To reduce substance use on release from prison	Cognitive-behavioural. Relapse prevention. Maintenance sessions; Preparation for release, Community programming	Cognitive behavioural treatment methods likely to be effective in reducing recidivism. Group counselling not likely to be effective
	12 step programs	Pearson and Lipton (1999)			More effective in preventing relapses than in reducing recidivism.
	Medical and pharmacological (e.g., methadone maintenance)	National Methadone Maintenance Program (Johnson, 2001)		Medical	Reduce crimes associated with heroin addiction. Improved outcomes when linked with counselling in the community (Kraft, 2002)
	Residential treatment	USA: AMITY Therapeutic community (Wexler, 1997)		Intensive, long term, self-help, highly structured, residential treatment	Strongest evidence for program effectiveness comes from evaluations of intensive residential programs, such as therapeutic communities. Greatest reductions in recidivism when followed up with residential community based aftercare.
	Boot camps	Pearson and Lipton (1999)			Largely ineffective in reducing either substance use or recidivism when compared to no-treatment comparison groups.
	Group Counselling Programs	Pearson and Lipton (1999)			In isolation don't lead to significant reductions in recidivism
	Driving Under the Influence programs	Deyoung (1997)		Education and counselling	
Transitional programs	Pre-release programs	CANADA: Canadian Offender Substance Abuse Pre-Release Program (OSAPP; Delnef, 2001) USA: New Vision ITC + Transitional TC	Address the substance use needs of offenders with intermediate-to-substantial problems Reduce recidivism among substance misusing offenders	Multi-faceted, cognitive-behavioural In-prison TC followed by residential community-based aftercare	Offender performance during OSAP program predictive of subsequent substance use behaviour and re-admission. Improvement a pre-requisite of meaningful decreases in recidivism. Better outcomes for those who attend other substance use programs in the community (i.e. Alcoholics and Narcotics Anonymous) Effective prison-based programming requires a continuum of care including re-integrative processes.
Community Programs	DUI recidivism programs	Meta-analysis (Wells-Parker and Bangert-Drowns, 1995)	Drink Driving Offenders	Education, psychotherapy/co counselling, contact probation	Combination of modalities considered to be most effective overall as they deliver 'something for everyone'.
	Alcohol Education Programs	Baldwin et al. (1991)		Education	Behavioural programs may be more effective than counselling-based approaches
	Community non-residential programs for offenders	CANADA: Choices (Delnef, 2001)	Offenders with low-low/moderate substance abuse problems on conditional release	Brief intensive phase followed by 12wks maintenance	Completion of maintenance phase associated with lower rates of re-admission to prison
	Community residential programs	Melnick, DeLeon, Thomas, Kressel and Wexler (2001)	Graduates of Amity TC		Significant path between in-prison motivation & program participation, voluntary entry into aftercare and reductions in recidivism.

Good Practice in Correctional Substance use Treatment

Defining 'Good Practice'

'Good practice', 'best practice' and 'world's best practice' are terms that are commonly used in correctional settings, but less frequently defined. Generally, terms such as these refer to approaches that can demonstrate some empirical support or evidence base for their effectiveness. Claims that a program constitutes 'good practice' should, therefore, be based on evidence of positive outcomes from evaluations of specific programs, or as Andrews (1998) has argued, from evidence regarding differential outcomes between studies of rehabilitation programs. It is probably only in the last five years that it has been possible to use the term 'evidence-based' to describe the rehabilitation of offenders (Day & Howells, 2002).

There is an emerging consensus about the characteristics of the most effective offender rehabilitation programs. Andrews (1998) has suggested that effective programs are associated with an average effect size greater than the overall average of ten percentage points. Canadian researchers have presented evidence that appropriately designed services produce an average reduction in recidivism of over 50%, compared with (according to their criteria) 'inappropriate services' which lead to increased recidivism. Of the 35 studies of 'appropriate services' reviewed by Andrews et al. (1990), all but two found reduced recidivism. These researchers have developed a set of general principles for use in program selection and delivery, which can be used to determine the general appropriateness of a particular program. For example, programs that select appropriate candidates for treatment have been shown to be more successful than those that do not. In the following section of the report, we briefly describe each of the main principles, before commenting on any particular issues that may be relevant to the application of the principle to offender substance use treatment.

General principles of rehabilitation service delivery for offenders

Risk

One of the most important principles in the general offender rehabilitation literature is known as the risk principle (Andrews et al., 1998). The risk principle suggests that programs are more effective when the intensity of programs is matched to the level of risk of re-offending of the individual offender. Whilst this principle has been accepted as an important aspect of service delivery in the general offender rehabilitation literature (see Day & Howells, 2002), there is less emphasis in the substance use literature on targeting intervention at higher risk offenders. This is despite “convincing evidence that a relatively few severe substance abusers are responsible for an extraordinary proportion of crime” (Wexler et al., 1993, p.212).

In a recent meta-analysis, Dowden and Brown (2002) looked at the extent to which substance use factors predict recidivism, finding a mean effect size of .10 between substance use and general recidivism. Combined alcohol and drug problems were most predictive of recidivism (.22), followed by drug use (.19), parental substance use (.13) and alcohol use (.12). These findings suggest that not only is substance use appropriately regarded as a risk factor for offending, but that some types of substance use are higher risk than others. In particular, those with combined drug and alcohol problems are at particular risk of re-offending. It follows from the risk principle that the most intensive services should be offered to this group.

Gendreau, Goggin and Annis (1990) in a survey of 170 substance use programs operating within the Correctional Service of Canada, found that only 26% of programs summarised assessment results in a way that would give some indication of risk. A majority (61%) did not vary the intensity of the treatment with the risk level of the client. This survey also revealed that correctional substance use programs varied considerably in terms of intensity, ranging from one day to one year.

One reason for the apparent lack of attention given to risk assessment in many substance use programs is that these programs have commonly been direct applications of community health-based approaches to offender populations. In health models, the focus of treatment is on meeting clinical need and on improving the health

and well-being of clients. The concept of ‘stepped care’ has been influential in helping to guide decisions about the type of service that is most appropriate for whom. The underlying principle of stepped care is to use the least intensive intervention that is thought to have a reasonable chance of success (Sobell & Sobell, 1999). In the stepped care model, failure to respond to treatment leads to further assessment and referral on to more intensive or alternative treatment programs. This model is commonplace in both physical and mental health services around the world.

In contrast, the risk principle suggests that (relatively independently of level of need), higher risk offenders should receive programs that are more intensive. Whilst we are not aware of any direct empirical support for varying the intensity of programs according to level of risk specifically to substance misusing offenders, we believe that the risk principle is still likely to be useful in treatment planning for substance using offenders.

There is some evidence to suggest that pre-release programming may effectively target offenders who are at low risk of recidivism, where level of risk is determined by an offender’s criminal history (Porporino et al., 2002). While selection for participation in the Canadian pre-release program (OSAPP, described above) was not contingent upon risk assessment, analysis of post-release outcomes for offenders classified as ‘low’, ‘medium’ or ‘high’ recidivism risk (according to criminal history) suggested that those with the least extensive criminal histories (‘low’) benefited the most from program participation with a 27% reduction in recidivism compared to 12% for ‘high’ and 6% for ‘medium’. With regard to individual offenders’ substance abuse severity, the largest treatment effects were observed for those who had the highest levels of substance abuse severity. Summarising these results, the authors concluded that “the OSAPP program should be targeted most effectively for severe substance users who have committed violent offences, but who may not have particularly extensive criminal histories” (Porporino et al., 2002, p.1063). While this conclusion appears inconsistent with the risk principle, most offenders with extremely high levels of substance abuse severity would be likely to fall into the moderate/high risk categories of standardised recidivism measures such as the Level of Service Inventory – Revised (LSI-R).

Although outside of the scope of this review, we would argue that there is a strong case for the diversion of low risk offenders with substance use problems away from the criminal justice system. Diversion programs, including drug courts, are now commonplace around Australia and potentially form an important part of an integrated service response to substance using offenders.

Although some reviews of drug and alcohol treatment studies (largely conducted outside of prison settings) have reported that there is no evidence for more intensive programs producing better outcomes (for example, Annis, 1990 suggests that residential treatment lasting 1-2 weeks produced results comparable with programs lasting several months and that day-treatment programs might be equally as effective as residential programs), the concept of matching client characteristics to different treatment types is receiving increasing attention (Sobell & Sobell, 1999).

Criminogenic Need

Andrews, Bonta and Hoge (1990) have argued that the focus of rehabilitation efforts should be on dynamic risk factors (those that can change over time), the most important of which have been termed criminogenic needs. This has become known as the needs principle. The extent to which substance use should be regarded as a criminogenic need is an important issue if services are to adhere to the needs principle.

Research from around the world has consistently found a close statistical relationship between substance use and offending (Weekes, Moser & Langevin, 1997; Hammersley, Forsyth & Lavelle, 1990; Kevin, 1992a,b). There is convincing evidence that crime rates are higher among drug-dependent offenders than non-misusing offenders, that a substantial proportion of offenders are dependent on drugs, and that most drug misusing offenders have significant life-style problems associated with substance use (Wexler & Lipton, 1993). Furthermore, as the extent of use increases, the frequency and severity of crime escalates (Chaiken, 1986), with some studies showing that active heroin use accelerates the users' crime rate by a factor of four to six. Similar findings have been reported for those misusing crack (see Ball, 1986; Brownstein & Goldstein, 1990) and for those misusing alcohol (Boles &

Miotto, 2003; Fergusson, Lynskey & Horwood, 1996). Dowden and Brown (2002) have reported research suggesting that more than 50% of offenders acknowledge a link between substance use and criminal involvement, including both general and violent offending (US Bureau of Statistics, 1983a, 1993b; Weekes, Fabiano, Porporino, Robinson & Millson, 1993). The Australian Institute of Criminology is currently conducting a three year project (involving NT, TAS, QLD & WA), entitled Drug Use Careers of Offenders (DUCO), which seeks to measure drug use, including illicit drug use, amongst sentenced offenders and to examine the intersection of drug use patterns and criminal careers.

Clearly different types of crime will be related to drug and alcohol use in different ways. It is self-evident that whilst some crimes are drug specific (such as where drug possession, use, and/or sale *is* the crime), others are not. Illicit drug use will, however, often create an economic need that leads to acquisitive offences. Of the illicit drugs, crack cocaine is the most likely to lead to violence (Boles & Miotto, 2003).

Even when crime and substance use co-exist, the relationship between the two variables may not be causal. A number of theoretical analyses have pointed to three possible interpretations: (1) substance use directly contributes to offending; (2) offending leads to substance use; and (3) both offending and substance use are caused by a third variable (e.g., deviant lifestyle, personality traits, genetics). Two broad classes of causal theories are the dis-inhibition model (where the pharmacological properties of substance use lower criminal and other inhibitions that normally restrain an individual from antisocial behaviour) and the social learning model (according to which individuals learn to behave in certain ways when intoxicated).

An important question for practitioners working within the criminal justice system is the extent to which substance use is a causal factor in an individual's offending, or in other words, the extent to which substance use might be considered as criminogenic. Daffern and Howells (2002) have suggested that a functional rather than a structural (diagnostic) assessment approach, which seeks to clearly and systematically identify the pathways to offending for the individual offender, is best suited to this task. The purpose of this type of assessment is to determine the extent to

which substance use plays a role in offending, and to inform decision making about the most appropriate treatment option. In theory, the individual functional analysis will lead to a decision to refer either to a correctional program or a health service. In practice, however, such decisions are often not easily made given the difficulty of the task of specifying the exact relationship and crime for a particular offender. In a recent paper (Day, Howells, Heseltine & Casey, in press), we have argued that programs should pay greater attention to mediating and moderating factors in the substance use-offending behaviour relationship.

A direct implication of the criminogenic approach is that those offenders whose substance use is causally related to their offending should receive priority for treatment. Whilst, it follows logically that adherence to the criminogenic needs principle will improve the impact of correctional treatment upon recidivism, there are many who would argue that treatment should be targeted to those with highest level of dependency (regardless of whether this dependency is criminogenic or not). This issue has been particularly controversial in the UK and highlights a philosophical difference between a risk management approach to intervention and a health care model of treatment.

In practice, however, substance use problems may be criminogenic for a large proportion of offenders. For example, Dobinson and Ward (1986) reported that 90% of a sample of New South Wales prisoners with identified drug problems reported committing their offence to finance substance use. For these offenders, substance use will clearly be a criminogenic need and a target of intervention. The issue is then one of what are appropriate services for those offenders who use substances, but where this has no causal relationship to their offending.

Some existing programs already use criminogenic need as a means of selecting appropriate substance misusing offenders for treatment. For example, the Canadian Offender Substance Abuse Pre-release Program (OSAPP) targets offenders for whom substance use is identified as a criminogenic need. An evaluation of the effectiveness of OSAPP on recidivism suggests that the program was most beneficial for offenders with the highest levels of substance use severity, with a reduction in recidivism of 18% for this group (Porporino et al., 2002). Offenders classified as low or moderately

severe substance users did not show a significant reduction in recidivism following completion of the program. Severity of drug and alcohol use was assessed prior to program participation using the Alcohol Dependence Scale (ADS; Skinner & Allen, 1982), the Problems Related to Drinking Scale (PRD; Cannell & Favazza, 1978), and the Drug Abuse Screening Test (DAST; Skinner, 1982). In this program, offenders with only low levels of substance use severity are not given priority access to intensive programs.

The Kowhai Alcohol and Drug Treatment Unit at Rolleston Prison in New Zealand also identifies substance mis-use or dependence as a key criminogenic need. Whereas offenders have previously been admitted to substance use programs following the identification of a substance ‘problem’ at pre-sentencing (where offender motivation is arguably enhanced by impending imprisonment), inclusion in the Kowhai program is dependent not on levels of substance use severity but “on whether there is a direct relationship with criminal behaviour” (Huriwai, 2002, p.1038). Being an intensive, client-specific, behaviourally-oriented treatment program targeting criminogenic needs, evidence-based principles would suggest that the Kowhai treatment approach should lead to reductions in recidivism, however as yet there has been insufficient evaluation of this program to demonstrate this.

Responsivity

Drug and alcohol services have led the rehabilitation field in the development and delivery of responsive services. The range of programs offered to offenders reflects attempts by service providers to develop programs that meet individual needs and to match clients to different treatment options to improve outcomes (Annis, 1990). Annis suggests that the severity of the problem and the degree of motivation to address the problem should be matched to the intervention offered. The extent to which these efforts to match clients to treatment are successful in leading to further reductions in recidivism, remains an important area for further research (Annis, 1990).

Project MATCH was an 8-year, multi-site study in the USA designed to test the general assumption that treatment outcomes can be improved by carefully

matching individuals, based upon their personal characteristics, to specific therapeutic approaches (Project MATCH Research Group, 1997). A total of 1,726 individuals with alcohol problems of varying severity were randomly assigned to one of three individually delivered treatments: 1) a 12-session twelve-step facilitation therapy designed to help patients become engaged in the fellowship of Alcoholics Anonymous; 2) a 12-session cognitive-behavioural therapy designed to teach patients coping skills to prevent relapse to drinking; and 3) a motivational enhancement therapy designed to increase motivation for and commitment to change, consisting of 4 sessions over 12 weeks. Contrary to prediction, no significant differences were found among the three treatments for patients with moderate to severe psychological problems (Project MATCH Research Group, 1997).

Motivation to attend for treatment is widely regarded as a key issue if prison programs are to be effective (McMurran, 2003; Gorta, 1992; Hall, 1997). One study reported that almost one third of pharmacologically dependent offenders did not want in-prison treatment for their drug problem (see Incorvaia & Baldwin, 1997).

A significant contribution to the field has been the development of models describing how people move through a predictable series of stages as the costs and benefits of their substance use varies (e.g., Prochaska & DiClemente, 1986, 1996). These models of change suggest that rehabilitation efforts should be targeted at the individual's location in this cycle of change. For example, educational programs aimed at improving motivation may be most appropriately aimed at those offenders who are reluctant to enter more formal treatment programs. An alternative strategy has been to develop different types of intervention designed specifically to encourage participation in treatment. The technique of motivational interviewing (Miller & Rollnick, 1991) has been particularly influential in this area. Motivational enhancement therapy is thought to be particularly effective with clients who are high in anger (Project MATCH Research Group, 1997).

The issue of treatment non-completion is a particularly important one that relates directly to the responsivity principle. Hiller, Knight and Simpson (1999) argue that many offenders prematurely drop out of transition and community after-care programs once the legislatively mandated component of their treatment is completed.

In their therapeutic community (TC) program, they found that recidivism rates were lower for those that had completed both stages of the treatment (36% of the TC only group compared with 30% of those offenders who completed the in-prison TC program *and* the transitional program had been arrested for a new offence). All of these offenders had been assessed using the Wisconsin system for classifying risk, with 71% classified as being at medium or high risk for recidivism.

The extent to which treatment should be coerced or mandated is a major responsibility issue in offender substance use programming. Farabee, Prendergast and Anglin (1998) reviewed 11 studies on compulsory substance use treatment. They conclude that research “supports the use of the criminal justice system as an effective source of treatment referral, as well as a means for enhancing retention and compliance” (p.4). However, the nature of the relationship between compulsion and treatment outcome is unclear, with the client’s perception of coercion in the legal process appearing to be just as important as their actual legal status (Day, Tucker & Howells, *in press*). It seems unlikely that legal status by itself will consistently impact on treatment motivation. Wild et al. (1998) reported that whilst 37% of self-referred clients felt coerced, a similar proportion of court-referred clients (35%) felt no coercion. In another study, Maxwell (2000) investigated the effects of sanctions on offenders’ perceptions of threat and retention in drug treatment, finding that legal pressure and legal status have independent significant effects on retention. Finally, Young (2002) studied 161 offenders mandated to attend a long-term residential drug treatment program. Results suggested that providing offenders with information about the treatment and convincing them rules will be enforced are effective forms of coercion. However, other forms of coercion, including tight monitoring and severe penalties, were found to be less effective.

Findings on the effects of coercion with non-offender populations have also been mixed. Goldsmith and Latessa (2001) discuss four major outcome studies over the past 40 years, involving 70,000 addicts (Drug Abuse Reporting Project; Treatment Outcome Prospective Study; Drug Abuse Treatment Outcome Study; and the National Treatment Improvement and Evaluation Study). Two major findings about coercion resulted from this work. Firstly, length of time predicts treatment efficacy, in that the longer the client is in treatment, the greater the treatment effect. Secondly, results

suggested that coerced addicts stay in treatment longer than those who are not coerced. This suggests that it is the coercion that led to greater treatment efficacy, although any direct relationship between coercion and treatment has yet to be established. In contrast, Prendergast, Farabee, Cartier and Henkin (2002) examined the psychological and social functioning of clients at different points in a drug treatment program. They found that, regardless of whether clients were mandated or voluntary, participants showed significant changes in psychosocial functioning throughout the treatment process.

Dual Diagnosis Offenders

Offenders with co-occurring disorders are a high needs group, with a range of problems in employment, relationships, health, and a reduced capacity to benefit from standard interventions for offenders. Peters and Bartoi (1997) suggest that these offenders are more likely to be terminated from programs or to leave programs early; are more likely to be non-compliant with treatment requirements; and generally have poor outcomes in offender substance use programs. Given that drug and alcohol use predicts recidivism in mentally disordered offenders as well as non-mentally disordered offenders, it follows that effective programs need to be high in responsivity, that is they should be adapted to the particular needs of offenders with co-occurring disorders (see Day & Howells, 2003).

Although treatment gains for personality-disordered substance users participating in general substance programs are generally fewer than those for non-personality-disordered substance users, treatment does lead to reduced substance use and symptomatology over time (Brooner et al., 1998; Cecero et al., 1999; Kokkevi et al., 1998; Linehan et al., 1999). Loza's (1993) survey of prisoners' substance use and treatment needs found that polysubstance users tended to be the most numerous, have the most treatment needs, and exhibit greater psychopathic deviance, compared to either drug-only or alcohol-only users.

Other studies have shown that substance use treatment reduces crime in those with antisocial personality disorder, but not those with borderline personality disorders (Hernandez-Avila et al., 2000), although this group is more likely to drop

out of substance use treatment. It has been suggested, however, that substance use may be related more to co-morbid depression than to personality disorder (Kokkevi et al., 1998). Since treatment completion is important to a good outcome, it is important to assess for and treat depression in substance users, with or without personality disorders. For some clients, of course, withdrawal from substances may actually be the cause of low mood.

Given the complex interaction of substance use and mental illness for those offenders described as having dual-diagnosis, integrated residential treatment units specialized for dual-diagnosis clients are typically recommended as the most appropriate treatment approach for such offenders (Johns, 1997). Programmes designed for the treatment of co-morbid mental illness and substance use require the integration of mental health and substance use treatment philosophies into a unified conceptual framework (Minkoff, 1989). In addition to offering integrated treatment, effective intervention with mentally ill substance users should include assertive outreach and intensive supervision, motivating clients to change, attention to broader issues in life such as relationships, work, leisure and accommodation, and a long-term intervention, bearing in mind the potential for relapse to both mental illness and substance use (Drake et al., 1993).

Substance use treatment also needs to be adapted for clients with intellectual difficulties. A simpler, less confrontative, more behavioural and directive and longer duration intervention may be required for these clients. Styles of presentation and interaction should be modified to suit the needs of this group (McMurran & Lismore, 1993).

Women Offenders

Female offenders have a particularly high rate of substance use problems, and substance use in women offenders is generally regarded as one amongst multiple criminogenic needs (i.e., associates, attitudes, employment, marital/family, personal/emotional; as assessed by the Case Needs Identification and Analysis assessment system used in Canadian corrections). Female substance using offenders tend to have higher overall need level ratings, and also higher risk ratings, than non substance-using female offenders (Dowden & Blanchette, 2002). Statistics from

DPFC (Victoria's female prison), suggest that women prisoners had the highest use of both licit and illicit substances for all Victorian prisons during 1999-2000 (Armytage et al., 2000, as cited in Sorbello, Eccleston, Ward & Jones, 2002).

The pattern of women's substance use is thought to differ from those of men in a number of ways (Wanberg & Milkman, 1998). For example, while alcoholic women generally drink less than alcoholic males, they are more likely to use other sedative drugs in combination (Blume, 1986). Women tend to fit the solo, isolative pattern of use rather than the gregarious, convivial pattern, although this difference has attenuated over the past 20 years (Schmidt, Klee & Ames, 1990). Women also tend more than men to use alcohol and drugs as a means for managing moods and psychological distress (Schmidt et al., 1990).

A report on women in prison by H.M. Chief Inspector of Prisons (1997) argues that substance use has different antecedents for women than men and serves different functions (see also Byrne & Howells, 2002). Primarily, drugs and alcohol are argued to serve the function of 'numbing' emotion for women. Given this, it has been argued that traditional drug treatment programs are inadequate in addressing the multitude of gender-specific physical, psychological, social and welfare needs found among female substance misusing offenders (Sorbello et al., 2002). The combination of a range of traumas (i.e., physical and/or sexual abuse, psychological/psychiatric issues) is thought to trigger maladaptive coping strategies, (including substance use) to reduce subjective distress. Langan and Pelissier (2001) argue that these differences suggest that treatment programs designed for men may be inappropriate for women.

Based on the Ward and Stewart (2003) enhancement model, Sorbello et al. (2002) recommend implementing a comprehensive, hierarchically-intensive and culturally-sensitive integrated treatment program, which incorporates various modules allowing for individualised treatment.

Wanberg and Milkman (1998) recommend several gender-specific treatment needs for women with drug and alcohol problems:

- attention should be given to a history of physical and sexual abuse

- concurrent mental health and medical problems should be assessed
- parenting education and information about foetal substance use effects, AIDS prevention and other STD's
- female role models, including women staff who have overcome alcohol or substance use
- assertiveness training to overcome characteristically low self-esteem
- issues of sexism in relation to the client's own experience
- recognition that therapeutic dependence may reinforce social stereotyping and self-fulfilling prophecy that women can't make it on their own
- special populations need focussed attention (i.e. lesbian women who appear to have higher alcohol or drug dependency problems)
- sensitive topics (such as sexual abuse) may be more thoroughly and appropriately discussed in individual counselling or all-female groups (i.e. no male staff members)

There are few empirical evaluations of substance use programs for women offenders. In a Canadian study, female substance-misusing offenders who successfully completed a planned treatment program were found to be significantly less likely to re-offend than their untreated counterparts (Dowden & Blanchette, 1999; 2002). Other research has suggested that there are some women for whom drug treatment is unlikely to be particularly effective. Richards, Casey and Lucente (2003) reported a relationship between psychopathy scores and poor treatment response (including program non-completion, non-compliance, rule violations and avoidance of urinalysis testing) in sample of 404 female prisoners attending a substance use treatment program in the USA.

The Victorian Community Residential and Outreach Program is a program based on the enhancement model described above. This program assists young women in identifying and managing significant life issues which interfere with their ability to live drug free lives. Preliminary data suggests that this type of program may be promising in reducing re-offending. Of the 55 women reported to have been involved in the program thus far, only 6 women have been returned to custody (Watt & Tomany, 2000, as cited in Sorbello et al., 2002).

Indigenous Offenders

Alcohol is commonly regarded as a particularly important area of need for many Indigenous offenders. In a small-scale Western Australian survey of those involved in Indigenous criminal justice programs, all informants viewed alcohol as an important contributing factor to Indigenous violence (Mals, Howells, Day & Hall, 2000). Those who had worked in remote areas believed that virtually *all* violent crimes committed by Indigenous men were alcohol-related. Few informants offered any comment as to the mechanism by which alcohol and violence might be linked, other than to suggest that everyday conflicts were more likely to escalate into violent confrontations under the influence of alcohol.

Such views are supported by criminological data. Hazelhurst (1987) has suggested that alcohol use could be a factor in up to 90 per cent of all Indigenous contacts with the justice system. Moreover, research has shown that in over half the incidents of homicide and serious assault committed by this offending population also involved the use of alcohol. For example, Strang's (1992) nationwide study of homicides examined whether the offender had been under the influence of alcohol at the time of the offence. While she found overall that 75% of the perpetrators had been affected by alcohol, the percentage of Indigenous offenders so affected was about twice that of the non-Indigenous offenders. Easteal's (1993) study of homicides between intimate partners also examined whether or not the offender had consumed alcohol immediately before the killing. She found that among Indigenous offenders, 89% were so affected, whereas the corresponding figure for non-Indigenous offenders was 65%. Although Indigenous drinking levels are actually lower than that for the general population, there seems to be a "high incidence of dangerous consumption levels" (Lincoln & Wilson, 1994, p.62), particularly amongst young men.

Whilst an association between alcohol and offending in Indigenous groups is likely, there have been few accounts of how or why such links exist. It may be that the socio-economic position of minorities is a better guide to alcohol use and alcohol related violence than culture/ethnicity per se (Ward & Baldwin, 1997), or that alcohol use is a response to other areas of (non-criminogenic need). In the survey by Mals et al. (2000), Indigenous informants were in general agreement that Indigenous male

offenders (particularly younger-generation, urban-dwellers), suffered from low self-esteem and a pervasive sense of frustration, anger, and powerlessness. Some informants did, however, note that these problems were less marked in remote communities where the men typically had a more secure sense of identity.

An alternative explanation is that alcohol is a response to high levels of stress experienced by Indigenous communities. Raphael and Swan (1997) argued that high levels of loss, traumatic and premature mortality and family break-up all contribute to stress. The extended family structures of Aboriginal peoples mean that individuals have more exposure to bereavements, trauma, and loss, than non-Indigenous peoples. It has been argued that these experiences are likely to lead to higher levels of mental health problems, in particular depression and symptoms of post-traumatic stress (Raphael et al., 1998). Sansbury (1999) noted that: 25% of Aboriginal people living in the inner city or large towns have mental health problems associated with stressful life situations; that Aboriginal males are 80% more likely to commit suicide than non-Aboriginal males; and that more than 63% of Aboriginal people presenting to Aboriginal medical services have a significant level of distress, principally depression.

While the prevalence of mental illness among Indigenous people is high overall, it is likely to be even higher amongst the prison population. Sansbury (1999) suggested that over 50% of Indigenous women prisoners have a severe mental illness. These high levels of health and psychiatric problems have implications for the management of Indigenous people in prison. First, Sansbury has suggested that there is a need for culturally appropriate health and mental health services. Second, he points to links between mental illness and offending through substance use. Finally, he argues that many Indigenous people with mental health needs are incarcerated rather than treated.

A significant problem identified in the Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991) was the high level of alcohol consumption among young Aboriginal people, particularly in many remote communities where adult alcoholism is thought to be a major contributor to the reduced life-expectancy and high offending rates prevalent amongst adult populations. Although the issue of

substance use is a key element of public health policy throughout Australia, there has, only recently been concerted attempts to address this problem specifically among Indigenous youth.

Delfabbro and Day (2003) suggest that by far the most significant area of interest in Australia has been the problem of petrol-sniffing, “a form of addiction that has crippled many outback communities”, causing significant brain damage, social alienation and isolation, and ultimately death for many hundreds of young Indigenous people (MacLean & D’Abbs, 2000).

There has been some published work with Indigenous Canadian offenders that may also be relevant here. Whilst there are clear differences between the Indigenous peoples of Canada and Australia, the common experience of colonisation may mean that similar issues arise. Johnston’s (1997) survey of more than 500 incarcerated Indigenous Canadian offenders found that over 40% of his sample fell into the high risk/high needs category. He also reported that offenders in the sample had high frequencies of childhood problems, including early drug abuse (60.4%), alcohol abuse (57.9%), behavioural problems (57.1%), physical abuse (45.2%), sexual abuse (21.2%), severe poverty (35.3%), parental absence or neglect, (41.1%) and previous suicide attempt (20.5%). The case file data also revealed that extremely high proportions of the Indigenous offenders had identified needs in the areas of substance abuse (88.2%) and personal/emotional functioning (82.4%).

This research suggests that Indigenous offenders will have high rates of alcohol use, and co-occurring mental health problems. We have not identified any data on the prevalence of drug problems in this group, although petrol sniffing is regarded as a major problem in some rural and remote communities. Indigenous offenders may also be considered a high risk (of re-offending group). Preliminary data collected at the Melbourne Assessment Prison support such suggestions. Of a sample of 48 male and female offenders who received Tier 1 assessments (described later in this report), only two were classified as low risk/needs, with 19 as medium and 27 as high. Attendance in a substance use program was recommended for all but three of these 48 offenders

(data provided by M. Nuzzo, OCSC, 2003)⁴.

There are a number of responsivity issues involved in programming for Indigenous offenders. These have been outlined in an important recent paper by Jones et al. (2002). However, there is currently little data from which to base the effectiveness of different types of treatment modality for Indigenous substance using offenders (see also Day, Casey & Howells, 2003; Day, 2003).

Juvenile Offenders

Illicit substance use among young offenders is common, if not normal. In secure care, surveys have revealed high level of substance use. Putnins (2001) reported that around 80 per cent of people in secure care in South Australia, report high levels of marijuana use in the month before placement. A survey of 300 young people in custody in New South Wales (Zibert, Hando & Howard, 1994) suggested that 94 per cent had experimented with alcohol, over 90 per cent had tried cannabis, analgesics, nicotine and cough medicine, 33 per cent had tried psycho-stimulants such as amphetamines, 20 per cent had tried narcotics such as heroin, 20 per cent had used inhalants, and 14 per cent had tried cocaine. The average age at which drug use began was reported to be 11 years, with the average age for illicit drug use at 13 years. There have also been suggestions that young people in institutions become involved in drug use at an earlier age, and use a wider range of drugs more frequently (NYARS, 1997).

The incidence of alcohol and drug use amongst young adults suggests that both the patterns and functions of substance use may be different for young offenders than for older offenders. For example, peer pressure to take drugs may be more influential for late adolescents than for those in middle adulthood.

An important consideration in planning substance use services for young adult offenders will be the extent to which only moderate to high risk and needs younger offenders are offered treatment (in line with the risk principle). Such an approach would exclude some young adult offenders who are in the early stages of a substance

⁴ We understand that a separate project (the Victorian-specific risk/needs assessment process) has observed that whilst Koorie men are higher risk than mainstream prisoners, this is largely due to the effects of sex and age, rather than Indigenous status. We have not had access to this report.

use or dependency from treatment services. An alternative would be to offer this group some form of intervention within a secondary prevention, rather than offender rehabilitation model of service delivery. The goals of this type of intervention would be to prevent any escalation of substance use, rather than to reduce the risk of re-offending.

Services and programs for younger people are also often conceptualized differently. Young people are considered more difficult to engage in treatment services, and often service providers see the primary emphasis of their work as about engaging young people and developing some level of trust. Many juvenile justice staff see direct program referral as unlikely to be an effective method of intervention (see Day, Howells & Rickwood, 2003). In addition, programs need to be delivered in ways that are developmentally appropriate, both in terms of the skills required to participate and the way in which materials are developed and presented.

Other ‘what works’ principles and issues

The ‘what works’ literature also contains a number of suggestions about how programs should be designed and delivered. These provide a starting point for the development of criteria and standards against which current service delivery can be matched.

The Integrity Principle

In contrast to the demands made by the responsibility principle to individualise interventions, an important component of quality assurance has been to emphasise the need for program integrity. Program integrity refers to the extent to which an intervention program is delivered in practice as intended in theory and design (Hollin, 1995). Best practice intervention programs build in integrity monitoring as a routine part of service delivery. Despite the need for intervention programs to be delivered both consistently and with integrity, it is also clear that intervention programs with young people should also have sufficient flexibility to deal with crises as they arise.

Using co-facilitators is one way to ensure that program integrity is maintained and that program drift is minimised. Running groups with two facilitators may also be indicated on clinical grounds – it is likely that two facilitators will be better able to attend to the changing needs of individuals within the group, be less influenced by personal interests and ideologies, and be better able to manage conflict. In some therapeutic traditions, a second clinician is used as an observer whose role it is to help the group conductor to evaluate the appropriateness and relevance of interventions (Jones et al., 1971). Running programs with two facilitators may also help to prevent the burn-out of staff in the longer term. As such, having two facilitators deliver therapeutic groups is likely to not only improve program integrity, but all the extent to which programs are delivered in responsive ways.

Concerns have been raised regarding the nature and integrity of treatment services offered in therapeutic communities (TC), and how the delivery of this type of service relates to program effectiveness. A process evaluation by Taxman and Bouffard (2002) assessing the TC treatment services in six sites highlights the difficulties encountered in attempting to implement the long-term TC model in short-term settings, and provides an important caution for similar efforts with other types of programs in other facilities. A structured observation of six short-term programs (assessing the philosophy and goal of each treatment session, type of topics discussed, nature of the treatment processes, style of the therapy sessions and use of the peer group to facilitate change) determined that these programs were not being delivered with fidelity to the intended TC design. If the implementation of new programs is not faithful to the TC model (whose effectiveness has been well demonstrated), then the effectiveness of the newer programs may also not measure up to that of the original programs.

The Professional Discretion Principle

The principle of professional discretion allows for professionals to make decisions on the basis of other characteristics and situations not covered by the preceding principles. This is also likely to be an important part of effective substance use treatment where the contexts and functions of substance use are likely to vary dramatically for different individuals. In these circumstances, it makes sense to build

scope for professional judgement into any rehabilitation system, rather than rely upon the rigid administration of static principles.

Program Characteristics

In addition to targeting criminogenic needs, meta-analytic reviews of offender rehabilitation have also indicated that the most effective programs tend to utilise particular methods. It is usually recommended that treatment approaches for offenders involve methods that are concrete and do not require high levels of literacy. There is now a consensus that cognitive and behavioural methods are more successful than other types of treatment approach with offenders (Hollin, 1999). Cognitive-behavioural programs are structured, goal oriented and focus on the links between beliefs, attitudes and behaviour. Programs based on confrontation or direct deterrence have been consistently found to be less successful. Evaluations of other methods, such as social casework, physical challenge, restitution group counselling, family intervention, vocational training, employment and educational programs, have all produced mixed findings (McGuire, 1995).

Programs should be of sufficient intensity to be able to impact upon offending rates. For example, a six week program is unlikely to have a significant impact on offenders with 20 year histories of substance use and offending. Canadian researchers recommend that programs should be at least 100 hours and take place over a minimum of 3-4 months. Intense 100 hour programmes are suitable for the needs of high risk offenders, however it can be said that such an emphasis takes resources away from 'secondary' prevention or early intervention. In alcohol treatments, minimal intervention for early stage problem drinkers has been found to be effective, suggesting the potential for such interventions to work with offenders as well. However, given that the majority of forensic substance use treatment involves intensive work with high risk offenders, comment cannot as yet be made on the effectiveness of early intervention with an offender client group.

Broadly, there is an empirical basis in the literature to support the notion that group-delivered cognitive-behavioural methods are most likely to produce positive outcomes in intensive non-residential prison treatment programs. This is not

necessarily the case in community programs. One multi-centre, randomised clinical trial comparing the effectiveness of three manualised treatments (12-step based, cognitive behavioural and motivational enhancement), found that the approaches did not differ significantly in terms of treatment effectiveness (Project MATCH, 1997). Similarly, Sobell and Sobell (1995) found no significant differences in treatment outcome between guided self-help (a CBT motivational intervention for alcohol and drug users) when delivered either in groups or individually. Cognitive-behavioural methods may not, however, necessarily be the preferred treatment modality in substance use community based programs.

Assessment

One of the most important practice issue in implementing any framework based on the '*what works*' principles is the adoption of an assessment system that accurately identifies risk of re-offending and associated criminogenic needs. Information from these risk/needs assessments is used not only to plan individual service plans, but also to identify levels of need in specific groups within the correctional population. This type of assessment potentially offers important information about areas of unmet need, which can then be mapped against existing service provision.

Once an individual's risk of re-offending and level of criminogenic need have been established a decision can be made about referral into treatment. Detailed assessment of the substance use problem can then guide programming, and act therapeutically as an opening stage of treatment. McMurrin (2000) argues that this type of assessment serves two purposes. The first is to understand the nature and extent of substance use and crime for the individual, enabling targets for change and progress monitoring. Information for this type of assessment is usually obtained from a variety of sources, including interviews, diaries, official records and accounts from significant others. The second purpose of assessment is to understand the reasons why substance use and crime developed and have been maintained over the lifespan. McMurrin (2000) argues that risk factors for delinquency and substance use are highly similar, and there is some evidence to suggest a developmental sequence

describing those offenders who display problematic behaviours in continuity from childhood, through adolescence to adulthood.

This type of assessment, therefore, provides a detailed picture of both the current or presenting problems, and of the developmental context in which these problems arose. This allows for a detailed formulation of the individual's problems, and an ability to match individual needs to particular intervention strategies. Models of change (such as the Transtheoretical or Stages of Change model) are also commonly used to assess motivation and to determine which interventions are most appropriate.

Assessment instruments for substance use can be grouped into screening instruments; specific instruments for establishing treatment targets and monitoring change, and broad assessment tools that assess functioning in a number of areas to determine multiple needs. A review of assessment measures by Boland, Henderson and Baker (1998) concluded that there are a number of brief and reasonably accurate screening measures available together with some valid and reliable measures for assessing the severity of substance use problems. Kevin (1992a) and Incorvaia and Baldwin (1997) recommend the use of screening tools to assess all new reception prisoners to identify those in need of further assessment and service priorities.

Other measures have been designed to assess specific treatment targets such as identifying high risk situations and self-efficacy. Boland et al. (1998) argue that clinical ratings of whether someone uses alcohol or drugs may be unreliable and they recommend the use of instruments which operationalise definitions.

The authors of the Project REFORM report (Wexler, Blackmore & Lipton, 1991) recommend that three levels of assessment are needed to adequately categorize inmates targeted for treatment programs: firstly identifying the need for drug treatment, secondly conducting an in-depth assessment of program eligibility, and thirdly collecting sufficient background and baseline information to enable legitimate evaluations of program effectiveness on behavioural change. However, project REFORM suggests that highly elaborate assessment and individualized programming are not strictly necessary. First because inmate populations tend to be relatively

homogenous in their drug use histories and need patterns, and second because external factors, such as expected time to release are far more important than a detailed needs assessment in determining appropriate interventions.

Pre-intervention assessment is an integral part of the UK Addressing Substance-Related Offending (ASRO) (McMurrin & Priestley, 2001) program and serves four main purposes: (1) selection, (2) allocation to groups, (3) monitoring, and (4) evaluation. Not only does assessment form a motivating preliminary component to the programmes, it allows for post-intervention comparisons and information that may be compared against later outcomes, both in terms of short-term changes (i.e. on indicators of crime-related needs) and long-term changes (i.e. recidivism). Rather than forming an additional task for the client or correctional staff, post-tests are built into the sessions themselves.

Treatment

McMurrin (2000) lists a number of components of intervention that are likely to be associated with the most successful programs. These include motivating offenders to change, challenging antisocial attitudes and hostile beliefs, criminological harm reduction or focussing on risk factors that are relatively straightforward to alter, changing outcome expectancies, reducing substance use through behavioural self-control training, and improving emotional and impulse control. Other components thought to be valuable include interpersonal skills enhancement (e.g., assertiveness, negotiation and communication), relapse prevention (preparing the client to maintain change by identifying situations where there is a high relapse risk), and lifestyle modification.

Wexler and Blackmore (1991), in writing about project REFORM, suggest that those assessed as having 'moderate' drug problems and an indeterminate release date are best assigned to non-residential prison programs (that is, they reside in the general prison population and undertake programs such as peer group and individual counselling, self-guided drug education courses, AA/NA group meetings etc). Offenders with severe and chronic drug problems qualify for isolated residential treatment programs, which are particularly effective for inmates with a pending

release date. Programs can be brief (less than 6wks), short-term (6-8 wks), intermediate (5-9 months) or long-term (9-15 months) and qualifying criteria requires an expected release date appropriately close to anticipated completion of the program. These programs are typically staffed by ex-addict-offenders as both counsellors and role-models, and include structured daily routines involving group counselling, drug education, relapse prevention, urine monitoring, skill-building and educational/vocational programs.

An important variable influencing treatment outcome for residential programs appears to be the length of time spent in treatment. Wexler, Falkin and Lipton (1990) found a strong relationship between time in the program and treatment outcomes, with the percentage with no parole violations rising from 50% for those who remained less than 3 months to almost 80% for those in the program for between 9 and 12 months. An unexpected decline in positive outcomes was found after 12 months in treatment, suggesting that inmates who successfully complete the treatment phases of the program (typically 9-12 months) should be released to community settings as soon as possible. Similar results are reported by Field (1989; 1992). A more recent study by Siegal et al. (1999) reported that prisoners who spent at least 180 days in a therapeutic community were significantly less likely to be re-arrested or charged with violent drug related crimes.

Setting Characteristics

Successful rehabilitation depends not only on the type of treatment offered, but also upon the conditions under which treatment is delivered. Appropriate treatments delivered in community settings produce two to three times greater reductions in recidivism than prison based programs (Andrews et al., 1990). For general rehabilitation programs, it has been suggested both that the social climate of prisons works against the effective delivery of programs, and that recidivism is related more to what happens in the community than what subsequently happens in institutions (Clarke, 1985). The available evidence suggests that, on average, programs delivered in community settings produce better outcomes than those delivered in institutions. This may also apply to those programs targeting substance use, although we are not aware of any evidence to support this claim. Issues of

organisational resistance and staff motivation may need to be addressed before implementing programs in prisons. At the same time, prisons are more likely to contain those offenders with a medium to high risk of recidivism and therefore have a potential for more effective rehabilitation outcomes.

McGuire (2002) argues that meta analytic results indicate that, on balance, community-based interventions have larger effect sizes in reducing recidivism rates than those delivered in institutions (e.g. Andrews et al., 1990; Lipsey & Wilson 1998; Redondo, Sánchez-Meca & Garrido, 1999). When similar programmes were compared in their relative effects in institutional or community settings, the latter outperformed the former in terms of reduced recidivism in the ratio of approximately 1.75/1, though in other reviews the differential was somewhat lower than this at 1.33/1.

Rehabilitation programs frequently involve discrete therapeutic sessions, whether individual or group based, with the participant returning to their natural environment on completion of sessions. Where this natural environment is a justice agency or institution, the issue arises of the compatibility between the lessons learned in the therapeutic setting and the lessons learned on a daily basis within the institution itself. There is, therefore, a need to integrate the goals of specific interventions with the formal care plan for the individual offender but also with the less formal and broader philosophies and expectations of the institutional environment. Hodge, McMurrin and Hollin (1997) have further suggested that a limited number of one hour intervention sessions are likely to be inadequate in addressing some of the more complex criminogenic needs (e.g., changing antisocial attitudes). They suggest that, for some offenders, more intensive residential programs, using models of social therapy (such as those offered by therapeutic communities), may more be appropriate. This may be one reason why therapeutic community programs are amongst the most effective for substance misusing offenders.

An important issue in ensuring therapy session-system integration is the staffing of therapeutic groups and programs. Howells et al (1997) argue that one of the lessons to be learned from the “nothing works” era in prison rehabilitation is the need to engage prison officers, and the whole prison culture, in the process of

changing offending behaviour. In their view, one of the reasons for the perceived failure of rehabilitation was that treatments were delivered by the “new professionals” from psychology and social work, with prison officers being actively discouraged from involvement in treatment. Hall (1997) has argued that “in the absence of any rehabilitation role, and with the removal of many traditional duties ... the majority of officers were left with purely custodial roles. The dominant ideology of punishment (based on retribution and deterrence) remained unchanged for prison officers”.

Links with community services

Finally, it is important that prison-based programs are integrated with community services, particularly in the period shortly following release. In a study following offenders after release from prison, Zamble and Quinsey (1997) found that recidivists reported more problems in the period after release, and had fewer or less effective skills for coping with them. Recidivists more often experienced difficulties and had poorer strategies for managing negative emotional states, such as anger, anxiety and depression. They also thought more frequently about substance use and possible crimes, and less often about employment and the future in an optimistic light. They experienced greater fluctuation in emotional states in the 48 hours preceding a re-offence.

Linking prison and community services appears to be perhaps the critical factor in effective offender substance use treatment (see program evaluations described earlier in this report). Our literature review found that the effectiveness of many offender programs in reducing re-offending was substantially improved when offenders successfully engaged with community services post-release.

Staff Training

Researchers have strongly recommended that the staff responsible for program delivery receive adequate training and supervision (e.g., Andrews et al., 1998). Therapist skills should be matched with the type of program. It has been argued that therapists who have a concrete problem-solving style function best in highly structured programs. Others, such as Gendreau (1996), have suggested that

therapists should have at least an undergraduate degree or equivalent, and receive 3-6 months formal on-the-job training in the application of interventions.

Staff competencies are critical to the effective implementation of rehabilitation initiatives. This includes training to promote commitment to rehabilitation, and specific skills training in both assessment and program delivery. We are not aware of any universally recognised training pathway for those involved in program delivery in this area and many current substance use services are offered by a combination of prison staff, community drug agencies and volunteer groups. Some understanding of the theory underpinning a particular program, training in the model of intervention, counselling or group-work and familiarity with the offender rehabilitation literature would appear to be associated with good practice. In addition, established systems of supervision for facilitators would also be desirable. The Office of the Correctional Services Commissioner (paper 1) report is relevant in this context (Birgden & McLachlan, 2002). In paper 1, the authors suggest: “effective offender management requires attitudes and principles to be held by correctional staff that are conducive to encouraging behaviour change e.g., personal views supporting abstinence hinder a harm minimisation approach”.

Systemic and Organisational Issues

Despite the considerable need for treatment, there is some evidence to suggest that existing programs tend to be over-burdened, and most offenders receive either very limited treatment or none at all. In the USA, National Institute of Justice statistics show that although drug and alcohol counselling was available in nearly 90% of state and federal facilities, only 10-20% of prison inmates participated in treatment during their incarceration. Baldwin et al. (1991) argue that substance use has not traditionally been seen as a high priority in service planning, with ‘service provision being characterised by poor quality and intermittent delivery’ (p.13).

Lescheid et al. (2001) identify a number of systemic elements critical to the effective implementation of offender rehabilitation programs. These include a need for broad governmental and managerial support for correctional services in its efforts to adopt a systematic approach to offender rehabilitation, a shared understanding of rehabilitation between both specialist and generalist staff within corrections, and

between custodial and community program providers; and a need to support the sustainability of those programs that have demonstrated their effectiveness. They also commented on the importance of consistent leadership and commitment from the top to rehabilitation, community investment in the development of programs, and the critical importance of staff training.

What is good practice in correctional substance use treatment?

Suggestions as to what constitutes best practice in the drug and alcohol field for offenders are generally consistent with the principles identified in the broader ‘what works’ in offender rehabilitation literature (McMurrin, 2000). These broad criteria are described in the reducing re-offending framework of Corrections Victoria (described earlier in this review). In relation to substance use programs, Wexler and Lipton (1993) recommend the following as constituting good practice: an isolated treatment unit, motivated participants, committed and competent staff, adequate treatment duration, an array of treatment options, cooperative and supportive relationships with correctional staff and administrators and continuity of care that extends into the community. There is also a consensus that intensive relapse prevention strategies need to be incorporated into programs for substance misusing offenders with ineffective coping skills (Incorvaia & Baldwin, 1997). However, at present, many of these suggestions for best practice, although highly plausible, remain largely uninvestigated by empirical research with substance misusing offenders.

There have been few published accounts of good practice in offender substance use programming. However, the analysis of project REFORM in the USA (Wexler and Blackmore, 1991) suggests the following principles and guidelines for substance use treatment programs in correctional systems with the objective of reducing recidivism:

- Assist addict offenders to identify personal impediments to recovery.
- Provide addict offenders with incentives, positive or otherwise, to participate in recovery programs.
- Separate participants from general populations as soon as possible.

- Reinforce pro-social behaviours rather than attempting to directly reduce the frequency of negative behaviour.
- Establish clear, unambiguous rules and consequences for breaking such rules.
- Establish clear behavioural contingencies.
- Employ ex-offenders/ex-addict staff to serve as role models.
- Maintain treatment program integrity, autonomy, flexibility, openness, and fiscal and political support.
- Establish continuity of intervention, from outset of custody to termination of custody.
- Establish program evaluation systems and analyse cost-effectiveness

These suggestions regarding good practice for offender substance use programs, are, in our view, not incompatible with principles of effective treatment for substance use programs generally.

The National Institute on Drug Abuse (1999) specifies the following principles of effective treatment:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness (minimum 3 months).
6. Counselling (individual or group) and other behavioural therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with other behavioural therapies.
8. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.

9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programmes should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counselling to help patients modify or change behaviours that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Review of current program accreditation methods

An alternative (though related) way of defining good practice is to look at the criteria used in different jurisdictions to accredit offender rehabilitation programs. Recent years have seen the development of a number of offender rehabilitation program accreditation systems, with the most comprehensive system of accreditation being that used by the Home Office in the UK. An alternative method of program accreditation that is widely used in North America, is the Correctional Program Assessment Inventory (CPAI; Gendreau, 1996). In Australia, there is currently no national system of program accreditation, although the development of such a system is currently being discussed (Prisgrove, 2003) and developed in New South Wales.

Accreditation systems have been reviewed in a number of published papers, including those by Lipton et al (2000), Blud (2003) and Blud, Travers, Nugent and Thornton (2003). Generally the accreditation systems described in these papers (most commonly the Home Office system) maintain that in order to replicate the programme it is essential that clear documentation be available that will enable delivery staff to run the programme in the way in which it was designed, thus maintaining programme integrity. This requires the development of a number of manuals, including a **Theory Manual** (to describe the theoretical base for the programme and the model of change); a **Program Manual** (to describe each session of the programme in sufficient detail to enable any well-trained professional to run the programme in the intended fashion); an **Assessment and Evaluation Manual** (containing all assessment

and evaluation instruments used in the programme, guidance on their administration; and an explanation of the practical uses of the various applications and contents); a **Management Manual** (describing the selection, training, supervision and performance appraisal of staff; how offenders are selected for the programme; the ways in which offenders are assessed before, during and after the programme; the minimum operating conditions required to enable the programme to run as intended; arrangements for monitoring and evaluating the programme, including the assurance of programme and treatment integrity, and audit; the roles and responsibilities of managers and staff); and a **Staff Training Manual** (describing ...detailed training courses, including curriculum and training materials, for all staff involved in the programme; how staff competence to run the programme will be assured; how competence will be assessed at the end of training on a pass/fail basis; how performance will be reviewed regularly).

In addition to methods of program accreditation (described below), the Correctional Service Canada, and the Scottish Prison Service have recently developed specific standards for the design and delivery of offender substance use programs. These will be discussed in more detail in Stage 2 of this project.

The Canadian (CPAI) and Home Office systems draw heavily on the principles of effective practice, identified in meta-analytic reviews of the outcomes of treatments, to guide decisions about accreditation. Generally, to achieve accreditation, programs need to demonstrate their ability to meet standards in the following areas:

1. Theoretical Model of the Program

There is now a considerable research base regarding the factors that have been demonstrated to contribute to or reduce recidivism (The Correctional Service of Canada, 2002). It is expected that this knowledge base will be the starting point for the development of any new program, and that it will also be utilised to explain clearly how the program can be expected to reduce offending in clients (Blud, 2003).

2. Risk

In order to receive accreditation, programs must usually demonstrate that they select individuals for treatment on the basis of their risk scores. Bonta (2002) suggests that programs should seek to employ actuarial based risk-need assessment measures which are comprehensive (incorporate multi domain sampling of the factors associated with criminal conduct) and measure a wide range of factors, both static (historical) and dynamic (changeable) in nature, that are associated theoretically and empirically with criminal behaviour.

3. Criminogenic Need

To achieve accreditation, emphasis should be placed on the identification and reduction of criminogenic needs (dynamic risk factors) or those factors that the research evidence has demonstrated are highly likely to be causal of re-offending in those taking part, with less reliance or emphasis placed on the reduction of non-criminogenic needs (Andrews, Compendium 2000). The Correctional Service of Canada (2000) and the Joint Prison and Probation Accreditation Criteria (2000), assessment panel (UK) generally accept that a factor to be targeted by a program is criminogenic for general offending if it occurs on the following list:

- poor cognitive skills;
- anti-social attitudes and feelings;
- strong ties to and identification with anti-social/criminal models;
- weak social ties and identification with pro-social/non-criminal models;
- difficulty with self-management, decision making and pro-social interpersonal skills;
- dependency on alcohol and drugs;
- contingencies favouring criminal over pro-social behaviour;
- some adverse social or family circumstances.

4. Responsivity

Most accreditation systems require that efforts are made to design and deliver the programs in ways that are likely to suit the specific learning styles of the client group. Specific responsivity factors may include personality, ability, motivation, strengths, age,

gender, ethnicity/race, language, and various barriers to successful participation in service (Andrews, Compendium, 2000).

5. Effective Methods

Programmes are accredited that employ methods that have been demonstrated to be consistently effective with offenders (Joint Prison and Probation Panel Accreditation Criteria, 2000, pp.14). To be accredited the programme must:

- either use predominantly cognitive behavioural methods,
- or be a structured concept-based therapeutic community,
- or, if it uses other methods, propose a plausible combination of theoretical argument and analysis of research to justify their use with this particular type of offender in order to reduce offending behaviour. (The Joint Prison and Probation Accreditation Criteria, 2000, p.14).

6. Skills Oriented

The Home Office accreditation system suggests that programmes should teach skills that will make it easier for participants to avoid criminal activities and to engage successfully in legitimate ones (The Joint Prison and Probation Accreditation Criteria, 2000, pp.15). In this system, applicants are asked to describe why acquiring particular skills would make it easier to avoid criminal activities or to pursue legitimate activities successfully.

7. Multi-modal

The Home Office accreditation system argues that given the complexity of criminal behaviour, programs should address a range of conceptually distinct dynamic risk factors in an integrated and mutually reinforcing way (Joint Prison & Probation Accreditation Criteria, 2000, pp.15). To this extent they recommend that a program targets a number of criminogenic needs.

8. Treatment dosage

The amount, intensity, sequencing and spacing of intervention should be related to the seriousness and persistence of offending, and to the range and seriousness of the criminogenic factors typical of participants (Joint Prison and Probation Panel Accreditation Criteria, 2000, pp.16). Gendreau has suggested that ‘intensive services should occupy 40 – 70 percent of the offenders’ time while in a program and are of 3 – 9 months duration (Gendreau, 1996 pp.120) and that the treatment dosage should be 100 hours direct service.

9. Aftercare, structured follow-up, continuity of care, and relapse prevention

Most accreditation systems call for the ongoing monitoring of the program and progress of group members and to intervene when circumstances deteriorate or positive opportunities emerge. It is suggested that generally, and particularly for residential programs, it is important that programming be community-oriented and attend to family, associates, and other social settings. Specific and structured after care and follow up activities should be designed and in place. At a relapse-prevention level, high-risk situations and circumstances should be identified and low-risk alternative responses practiced.

10. Evaluation

A commitment to the ongoing evaluation of its effects should be built into the programme. In order to establish the link between the programme intervention and reconviction it is necessary to demonstrate that the programme achieved its objectives through interim measures designed to measure change in the targeted dynamic risk factors. These measures may be, in the short term an indicator that the programme is effective before reconviction data is available, and in the longer term will increase knowledge of how programmes produce change.

These criteria (above) show that existing accreditation systems base themselves largely on the ‘what works’ criteria, and require that in order to receive accreditation, a program will (as a minimum) adhere to the principles of risk, needs and responsivity. In addition, they make some requirement about treatment methods, staff qualifications and through-care, all of which are important components of an effective service delivery model.

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