Counseling, Treatment, and Intervention Methods with Juvenile and Adult Offenders

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attending an NA program. Kerr, the prisoner, stated that he was told by a prison social worker that attendance at NA was mandatory and Kerr had no choice but to attend. The penalty for not attending would be a transfer from the minimum security prison to a medium security prison. In addition, Kerr's records would indicate his nonattendance so that the parole board would be cognizant of Kerr's refusal to participate in drug treatment. The Seventh Circuit Judges stated that when a prisoner claims that the state is coercing religion on him or her, three questions need to be asked. First, has the state acted? Second, does the action constitute coercion? Third, is the object of the coercion religious or secular? In the Judges' opinion, the answers to the first two questions were yes and the answer to the third question was religious. Therefore, the prison administrators violated Kerr's First Amendment right. However, the Judges granted the prison superintendent and social worker qualified immunity because the right to be free from coercion involving NA was not an established right that a reasonable person would know (*Kerr v. Farrey*, 1996).

A few decisions have been rendered by U.S. District Courts regarding this issue. One court has rejected the challenge made to NA and AA and their religious contents. It used the reasonableness test and concluded that a rational basis existed between forcing prisoners into drug treatment programs and the government interests in reducing drug dependency, reducing recidivism, and increasing security (*Boyd v. Coughlin*, 1996). *Boyd* was decided by a New York District Court several months before *Kerr*. However, the emerging view by a number of courts seems consistent with *Kerr*. Several District Courts suggested that the lack or availability of treatment options affect whether prisoners have legitimate claims based on the Established Clause. A prison system that has only one option, AA or NA, violates prisoners' rights (*Scarpino v. Grosshiem*, 1994; *Warner v. Orange County Dept. of Probation*, 199[illegible]), whereas a prison that has several treatment options, in which AA or NA is one, does not violate prisoners' First Amendment rights (*O'Connor v. [illegible]*, 199[illegible]).

INVOLUNTARY TREATMENT OF SEX OFFENDERS

In the 1930s, states began to control some sex offenders by civilly committing them to mental institutions. In the 1960s, most states repealed their civil commitment statutes because mental health professionals expressed concern about the appropriateness of mental institutions for relatively minor sex offenders, the causes of sexual deviance, and civil rights concerns. In the late 1980s and 1990s, considerable attention has focused on serious sex offenders, and many states have retrieved civil commitment as a solution (Alexander, 1993b).

Unlike before, a major difference exists in civil commitment in the 1930s and civil commitment in the 1990s. In the 1930s, civil commitment occurred in lieu of imprisonment. But in the 1990s civil commitment occurs after sex offenders have served their sentences in a prison system. In some states, the mental health units where sex offenders are committed are located on the grounds of the prison. In effect, they are moved from one part of the prison to another. The use of civil commitment raises a series of issues, and the courts have grappled with these legal issues.

Mental illness and being a danger to self and others are required for civil commitment to a mental institution. Further, the act of dangerousness must be recent. One of the critical issues is whether sex offenders are mentally ill—a necessary justification for [illegible]commitment. On one hand, some professionals have argued that they are mentally ill (Fujimoto, 1993; Henderson & Kalichman, 1990), but others have argued that they are not (Alexander, 1995b; Erlinder, [illegible]3; LaFond, 1992; Reardon, [illegible] Weinstein, 1992). This debate aside, several courts have ruled that sex offenders who are nearing release from prison can be legally committed to mental institutions for an indefinite period (*In re Blodgett*, 1994; *In re Young*, 1993).

How states changed their laws is interesting. The Washington legislature, knowing that its definition of serious mental illness for ordinary citizens would not encompass sex offenders, created a new definition of mental disorder tailored to predatory sex offenders. It defined the sexually violent predator as "any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence." The term *mental abnormality* was defined as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others." *Predatory* was defined as "acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization" (Washington Statute, 71.09.060).

The Washington statute was applied to Andre Young and Vance Cunningham. On appeal to the Supreme Court of Washington, the Justices found that both Young and Cunningham met the criteria for civil commitment of mental illness. Justice Durham, writing for the majority, stated that mental abnormality is synonymous with personality disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Further, they both suffered from paraphilia. Therefore, Young and Cunningham were mentally ill. With respect to the issue of dangerousness, the Court ruled that Young, who was in prison when he was committed, could not be shown to be dangerous because of his confinement. So, his offense, which led to his criminal sentence, was evidence of his dangerousness. However, Cunningham, who had been released from prison when civil commitment proceedings were initiated against him, had to be shown to have committed a recent act that would be defined as dangerous. Therefore, the Washington court ruled that Young's civil commitment was legal, but Cunningham's was illegal (*In re Young*, 1993).

However, Young's civil commitment has become suspect in federal court. A U.S. District Court has ruled Washington's civil commitment statute for sex offenders unconstitutional. The U.S. District Court ruled that civil commitment constitutes a second punishment. Also, the District Court ruled that the law was unconstitutional because civil commitment required mental illness and Young was not mentally ill. Instead, Young had a personality disorder, which does not constitute mental illness. Finally, the U.S. District Court stated that the civil commitment statute was not law when Young was initially convicted of sexual assault ("Sex Predator Law," 1995).

Minnesota, which did not repeal its statute permitting civil commitment and had maintained it since the 1930s, permitted the civil commitment of sex offenders who evidenced a psychopathic personality disorder. However, the Minnesota Supreme Court refined the original definition. It was subsequently defined as "the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of personal acts, or a combination of any such conditions, as to render such person irresponsible for personal conduct with respect to sexual matters and thereby dangerous to other persons" (*In re Blodgett*, 1994, p. 919).

The Minnesota statute was applied to a prisoner named Blodgett who had a history of sex offenses and who was nearing release from prison. Because a psychologist concluded Blodgett met the definition of a psychopathic personality and was dangerous, Blodgett was committed to a mental institution. On appeal, the Minnesota Justices stated that psychopathic personality disorder was similar to personality disorder in the DSM-III-R. Further, the Justices concluded that Blodgett was dangerous based on his previous behaviors. Like the Washington Justices, the Minnesota Justices held the statute to be constitutional (*In re Blodgett*, 1994). When the U.S. Supreme Court refused to hear the appeal from Blodgett (*Blodgett v. Minnesota*, 1994), civil commitment of sex offenders established law.

In 1997, the U.S. Supreme Court appeared to settle the issue of the constitutionality of civil commitment for sex offenders. Kansas enacted a statute similar to the state of Washington. The Kansas statute permitted civil commitment for persons who had a mental abnormality or personality disorder and were likely to engage in predatory sexual violence. The Supreme Court of Kansas ruled that the conditions of mental abnormality and personality disorder did not satisfy the substantive requirement of mental illness and held the statute unconstitutional. However, the U.S. Supreme Court reversed the Supreme Court of Kansas' decision, holding that mental abnormality or personality disorder was sufficient. One of the additional issues was that civil commitment constituted an additional punishment. The Court rejected this argument. It ruled that the statute was not punitive even if Kansas failed to offer treatment where treatment for a condition was not possible or if treatment was possible was merely an ancillary rather than an overriding concern (*Kansas v. Hendricks*, 1997). The Court seemed to have relegated treatment to a secondary status, but it did not entirely eliminate it. The ruling seems to say that some sex offenders may be civilly committed even if no treatment exists for their problem or treatment was a secondary concern.

GENDER AND EQUAL PROTECTION IN PRISON TREATMENT PROGRAMS

At one time, the most active persons involved in filing lawsuits alleging deprivations of constitutional rights were male prisoners. Within the last couple of decades, female prisoners have become very active in challenging the conditions of their confinement. A difference exists in what male prisoners contended in their lawsuits and what females contended. Typically, male prisoners complained that they were entitled to certain rights based on the U.S. Constitution. However, female prisoners complained that their rights were violated because they were being denied equal protection of the law. Simply, female prisoners use programs provided in male prisons as the norm for what they should have. Initially, female prisoners were prevailing in their lawsuits, but recently they seem to have reached an impasse in this approach (*Keevan v. Smith*, 1996; *Klinger v. Department of Corrections*, 1997; *Glover v. Johnson*, 1996; *Goldyn v. Angelone*, 1994; *Jeldness v. Pearce*, 1994; *Women Prisoners of the Dist. of Columbia Dept. of Corrections v. District of Columbia*, 1996).

In an early case, a U.S. District Court in Michigan found that female prisoners' rights to equal protection of the law were violated because of a lack of parity between the educational and vocational programs at the male and female institutions. The court ordered the state of Michigan to provide comparable programs in the institution for female offenders (*Glover v. Johnson*, 1979). In another case, a female prisoner claimed that her conditions of confinement at a Virginia prison were dissimilar to male prisoners. The state of Virginia attempted to defend itself by noting the differences in the size of the two prisons. The women's prison was much smaller than the men's, which made the provision of programs in women's prisons much more expensive. The court stated that the evidence presented to the court was insufficient to make a decision and another hearing was necessary. Further, the court expressed sympathy for the budgetary pressures on correctional administrators, but such pressures could not be used to maintain an unconstitutional prison system (*Bukhari v. Hutto*, 1980).

Repeating the pronouncement that cost is an unacceptable defense to differences in men and women's prisons, a U.S. District Court in Virginia supported an equal protection challenge to the lack of a boot camp in an institution for females. The state of Virginia contended that limited resources and more pressing problems in male institutions influenced its decision to create a boot camp in the men's prison. In addition to military type drills, the camp included academic education, vocational assessment, and life skills training. The District Court stated that if Virginia's defense was accepted then there would be no programs in women's correctional institutions (*West v. Virginia Dep't of Corrections*, 1994).

However, the cost and equal protection arguments may be in difficulty because of a recent Eighth Circuit Court of Appeals decision. This case originated in Nebraska by women incarcerated at the Nebraska Center for Women (NCW). It was the only correctional institution for women in the state. The population ranged from 90 to 130 inmates of all classifications. In 1988, four women at NCW were in contact with male prisoners at Nebraska State Penitentiary (NSP). The women perceived that major differences existed between the two correctional institutions with respect to programming. They circulated a petition to the superintendent of NCW requesting equal programming. When this approach failed, they filed a lawsuit alleging sex discrimination and requesting monetary damages. The women alleged discrimination based on inequities in employment; economic, educational, vocational, and legal access; medical, dental, and mental health services; recreational services; and visitation.

In deciding these issues, the U.S. District Court stated that three tests were used in deciding equal protection analysis. The three are the strict scrutiny, heightened scrutiny, and rational basis or the reasonableness test described in *Turner v. Safley* (1987). Noting that previous courts have used the heightened scrutiny in cases involving equal protection analysis in prison cases, the District Court concluded that the proper test was heightened scrutiny. Based on it, the U.S. District Court found that female prisoners at NCW were discriminated against in pay for prison jobs, The actual CSC program was housed in a twenty-five-bed residential unit within the prison. New prisoners to the unit underwent an eight-week orientation. During this orientation, they were informed of the theory of the program. They were also told how to recognize frequent cognitive distortions and how to develop skills needed for cognitive–behavioral self-monitoring. After the initial phase, the offenders were assigned to a group, which consisted of between five and ten prisoners and several members of the treatment staff.

The groups met three to five times a week. During each group session, a designated prisoner was required to present a "thinking report" to the group. This report revealed prior acts of criminal behavior and current acts of antisocial behaviors. Typically, the prisoner provided an objective description of the criminal or antisocial behavior. Next, he would describe all the thoughts and feelings he had prior to, during, and after the crime or act. After the report, the group assisted the prisoner in identifying the cognitive distortions accompanying the behavior. Sometimes, the group engaged in role-playing to clarify its points. When prisoners learned their criminogenic thoughts, strategies were developed to block these thoughts from occurring. Of the cognitive strategies used, some were challenging one's cognition and cognitive redirection. Behaviorally, a strategy could be avoiding high-risk situations or discussions of cognitions and feelings.

Participants were required to give two reports a month. In addition, they completed homework that pertained to a thinking report on deviant behavior and kept journals. The treatment staff inspected the journals so as to give each prisoner regular feedback. Because the prisoners had to have six months or less to enter the program, treatment length reflected this condition.

To evaluate this treatment program, Henning and Frueh (1996) used a quasi-experimental design to test the effects of the CSC program. Prisoners who received treatment were compared with prisoners who had not taken the program. The outcome variable of interest was the amount of recidivism. According to their results, 50% of the prisoners who received the treatment engaged in recidivism compared to 70.8% of the prisoners who had not. This difference was statistically significant. Using a different statistical analysis, the researchers found that participation in CSC was a significant predictor of failure rate, such that at one year, CSC had a failure rate of 25%, two years 38%, and three years 46%, whereas the comparison group had a failure rate at one year of 46%, two years 67%, and three years 75% (Henning & Frueh, 1996).

Treating Clinically Depressed Prisoners

Some prisoners become clinically depressed while serving their sentences. Wilson (1990) studied the effectiveness of a group cognitive intervention for significantly depressed prisoners. He utilized a supportive, nondirective treatment approach as a comparison group, which had been shown in previous studies to be beneficial. The prisoners in the cognitive group treatment, during the first session, introduced themselves and discussed their concerns and goals. After establishment of the group rules, the group discussed the pamphlet Coping with Depression and the assignment of homework. In the subsequent thirteen sessions, the group focused on specific techniques (e.g., recording dysfunctional and functional thoughts, creating activity schedules, and completing rating scales) and group processes (e.g., modeling, attentiveness to group dynamics, and focusing on cognitions). Specifically, the prisoners were counseled to distinguish, challenge, and change dysfunctional thoughts. Also, they were encouraged to imbibe positive self-statements and envision pleasant activities. As far as the individual supportive group, the prisoners received a general therapy format, which focused on clarifying, through reflections, problematic issues. These prisoners were encouraged to discuss their moods, current functioning, and personal concerns with a counselor.

Assessments were done at pretreatment, midtreatment (i.e., six weeks after the first treatment session), and posttreatment. The outcome measures used were the Beck Depression Scale, the Multiple Affect Adjective Check List, the Hopelessness Scale, the Minnesota Multiphasic Personality Inventory (MMPI) D Scale, a Daily Mood Rating Scale, and a Consumer Satisfaction Questionnaire. Significant differences were found for the Beck Depression Scale and the MMPI D scale from pretest to midtest, and posttest. Particularly, prisoners who had cognitive group treatment experienced about a 50% reduction in the depression score compared to about a 25% reduction for individual supportive therapy (Wilson, 1990).

Treating Sex Offenders

Within the offender population, probably the most difficult offenders to treat are sex offenders (Furby, Weinrott, & Blackshaw, 1989). However, one longitudinal study showed some relatively positive preliminary results. The study was of the Sex Offender Treatment and Evaluation Project (SOTEP), which was operated by the California Department of Mental Health. SOTEP had two primary goals. One goal was to create and operate an innovative treatment program. The second goal was to perform a rigorous evaluation of the program.

Admittance into SOTEP required that an offender be convicted of rape or child molestation. Offenders who had participated in gang rapes or incest were excluded. Admittees had to have fourteen to thirty months to serve before release. In addition, there were some other requirements, such as they had to be between eighteen years old and sixty years old, they had to speak English, they had to have a maximum of two felony convictions, they had to have an IQ over eighty, they had to be free from any psychotic or organic impairment, they had to free from serious behavioral problems in prison, they had to be relatively physically fit so as not to require the services of a skilled nursing facility, they had to have no felony holds, and they had to admit their offenses.

After the initial screening and group assignment, prisoners accepted for the program were transferred to the Atascadero State Hospital. The average stay was about two years. When released from Atascadero, they spent a year in an aftercare program. The aftercare program was called the Sex Offender Aftercare Program (SOAP). Participation in SOAP is made as a condition of parole, and failure to participate can result in a return to prison. Then the men were tracked for a minimum of five years. Each man was interviewed annually to collect information about personal and social controls, coping styles, their degree of commitment to abstinence, self-efficacy, and self-report of deviant behavior. However, these data were additional information that was made possible by the National Institute of Mental Health.

The primary intent of the treatment program, however, was to treat the men's sexual offending and whether they sexually offended again was the primary outcome therapeutic community within one of the prisons that was called KEY and a work release program that was called CREST. KEY was Phase One and CREST was Phase Two. KEY consisted of twelve months in a therapeutic community within the prison. CREST consists of six months in a residential program. In Phase Three, they receive an additional six months of individual and group counseling after they were released and while they were on parole or other supervised release. In all phases, the emphasis was on correcting negative patterns of thinking, feelings, and behaving that promoted drug use. They also learn to take responsibility for their behavior and acquire positive social attitudes and behaviors that would lead to a drug-free lifestyle. While not stated, this emphasis espouses a cognitive–behavioral treatment approach.

Inciardi researched the effectiveness of the KEY/CREST program. He compared four groups consisting of offenders who participated in KEY only, CREST only, both KEY and CREST, and a no-treatment comparison group. The initial evaluation occurred six months after treatment and consisted of a total of 457 offenders. The outcome measures were whether the offenders were drug free and whether they were arrest free. The research showed that of the offenders that participated in both KEY and CREST, 95% of them were drug free and 97% were arrest free six months after treatment. Eighteen months after treatment, 76% of the offenders in both KEY and CREST were drug free, compared to 45% of the CREST only group, 30% of the KEY only group, and 19% of the comparison group. With respect to arrests, 71% of the offenders who were involved in both KEY and CREST were arrest free, compared to 65% of those offenders who were in CREST only, 48% who were in KEY only, and 30% who were in the comparison group. These results showed that an effective treatment program must consist of initial treatment in prison and a follow-up treatment program in the community. Hoping to evaluate the long-term effects of the program, the researcher planned to conduct subsequent follow-up at forty-two and fifty-four months after treatment (Mathias, 1995).

Martin, Butzin, and Inciardi (1995) conducted additional, multivariate analyses on the data involving the therapeutic community in the Delaware prison. The outcome measures of interest were whether released offenders were drug free, arrest free, injection free, and risky-sex free (e.g., were using condoms). They coded the type of treatment (i.e., KEY, CREST, KEY/CREST, and the comparison group) and entered them in a logistic regression. Participation in CREST and KEY/CREST was a significant predictor in being drug free and arrest free. Participation in CREST was a significant predictor in being injection free, and participation in KEY/CREST was a significant predictor in being risky-sex free. Martin and associates controlled for other variables and found that participation in KEY, CREST, and KEY/CREST were all significant predictors in being drug free and arrest free.

UNRESEARCHED PROGRAMS AND INTERVENTIONS

Drug Programs

A Federal Program Torres (1997), a retired federal probation officer and current university professor, rejects the medical model in providing a framework for intervening with substance-abusing offenders. Instead, he espouses a view that individuals choose to use drugs and have free will. The most effective strategy for

probation officers who work with drug offenders is to establish explicit limits, to tell probationers and parolees of the consequences of not following the rules, and to be prepared to enforce consequences for rule violations. According to Torres, "the preferred course of action for many, if not most, users is placement in a therapeutic community, with credible threats and coercion if necessary. If the probation officer concludes that such placement in not needed, then a system of graduated sanctions or consequences is appropriate for techniques violations, such as dirty tests" (p. 38). In short, an effective strategy is surveillance through frequent drug testing and treatment.

This philosophy was established in the 1980s as a policy directive in the Central District of California (CDC) and adopted by federal probation officers. As indicated by a position statement, one does not volunteer to be addicted and one's volition plays a critical role in addiction. The CDC does not support the belief that addiction is a disease or a medical problem. Drug abuse that leads to negative results or a physical disease, such as liver disease, is not in and of itself a disease. Diseases do not disappear simply because one wants them to go away, such as a heart disease or cancer. In terms of substance abuse addiction, it will not cease until a person decides to end it. The cause or cure for a disease is never a decision. As a result, drug use is not a disease.

The CDC acknowledges that some social problems, such as unemployment, dysfunctional families, and drug-infested neighborhoods, exacerbate drug use. However, there is no direct link between these social problems and drug use. A number of people experience various social pressures and do not use drugs. People initially use because of social influence, the desire to change one's state of mind, and availability. They continue to use because it becomes psychological, socially, and physically reinforcing. In the CDC, the use of drugs is approached from a legal perspective. It is violation of the law and a violation of conditions of probation and parole. An addicted offender cannot benefit from other services, such as employment training or counseling, until he or she is free of an addiction.

The CDC has a total abstinence policy for the protection of the community and the offender. The reasons for this goal are to reduce crimes stemming from drug abuse and assist the offender by helping him or her to stay out of the criminal justice system and reduce the likelihood of the offender dying from drugs or incurring serious mental and physical disabilities. These goals can be achieved in the following manner. The first goal is to help the offender make the decision to not use drugs. The second goal is to place the offender in a treatment program. The third goal is to return the offender to a correctional institution if use continues. The successful accomplishment of these goals is to provide regularly a sophisticated drug-use detection process, which employs urine drug testing and physical examination. The purpose is to communicate to the offender that he or she cannot use without being detected, and if detected, graduated sanctions are employed, including a return to prison. A number of offenders will get the message and develop motivation to not use. Offenders who do not get the message experience the consequences of their behavior, such as a return to prison. At some point, perhaps after repeated returns to prison, the offenders learn that if they want to stay free, they must stop using. When offenders have stopped, the probation officer can assist the offenders with other problems that they have.