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Motivation of incarcerated substance abusers with special needs towards treatment in therapeutic communities and other treatment modalities

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PREFACE

Nowadays, substance abuse is considered as an integrated bio-psycho-social problem, affecting multiple areas in people's life, including physical and psychological health, educational and professional activities, social network involvement and judicial status (Brochu, Guyon & Desjardins, 1999). Given this complex nature of addictive behaviors, treatment and research should be embedded in a broad context, not only tackling the substance abuse problem itself, but the associated problems as well (Scott, Muck & Foss, 2000). The current focus on special needs of recently identified '*new*' target groups, such as women, legally mandated offenders, dually diagnosed clients, adolescents, incarcerated substance abusers and ethnically and culturally diverse people, is an excellent example hereof (Lidz & Platt, 1995).
From this point of view, incarcerated criminal offenders constitute an important sub-group within the population of substance abusers, as over 80% of them are involved in drug-related behavior (Harrison, 2001). After - some would say a still ongoing - controversy about the issue whether correctional facilities should offer punishment or treatment to (substance abusing) offenders in the first place (Torres, 1996), recent views draw the attention on the effectiveness of (prison-based) substance abuse treatment for this specific target group, thus advocating rehabilitation over repression.
In this respect, growing international evidence-based research data point out that motivation and readiness towards treatment could be regarded at as quintessential concepts when treating drug-involved criminal offenders (De Leon, Melnick, Thomas, Kressel & Wexler, 2000; Hiller, Knight, Leukefeld & Simpson, 2002).

Therefore, the main purpose of this dissertation aims at mapping the motivation and readiness of drug-involved criminal offenders, who are incarcerated in Belgian correctional establishments, towards substance abuse treatment offered in (prison-based) therapeutic communities and other treatment modalities. Special attention will be given to those criminal offenders, who are specifically vulnerable because of special intellectual needs.

In *chapter 1*, current definitions of motivation and readiness towards change in general and substance abuse treatment more in particular are examined within the specific context of drug-involved behavior in correctional establishments. Moreover, the general aims, research questions and methodology of the studies, comprising this dissertation, are described.

Chapter 2 examines the historical development of the prison-based therapeutic community (TC) for substance abusers, as one of the most thoroughly studied treatment modalities for drug-involved criminal offenders. Two major traditions – the English democratic 'Maxwell Jones-type' TC and the American hierarchical concept-based TC – are highlighted and compared using five conceptual dichotomies, resulting in a critical examination of similarities and differences on the one side and an overview of actual tendencies in correction-based therapeutic communities on the other side.

In *chapter 3*, the actual tendencies in the therapeutic community for substance abusers, as described in chapter 2, are more thoroughly investigated by means of a case study, in which qualitative and quantitative research methodologies are combined. More specifically, the evolution in the confrontational encounter group method – the most essential tool in the TC – is investigated. The study empirically underpins clinical observations, which have important consequences for substance abusers, especially those with special needs targeted in this dissertation.

Chapters 4, 5, 6 and 7 go into the very subject of this dissertation and present findings on the characteristics – mainly focusing on substance abuse severity, intellectual abilities and both ethnical and cultural origin – of the participating incarcerated drug-involved offenders (chapters 4 and 5); as well as on results clarifying the motivational indices of drug-related behavior change (chapters 6 and 7).

In *chapter 4*, the usefulness and feasibility of integrated health and care paradigms for the assessment of intellectual abilities and substance abuse severity, which conceptually went through a comparable evolution, are investigated in a sample of incarcerated criminal offenders, on the basis of empirical pilot data.

Chapter 5 describes a qualitative study on treatment needs and expectancies of ethnically and culturally diverse clients in substance abuse treatment. As it turned out to be difficult to investigate those needs in a sample of substance abusing incarcerated criminal offenders, mainly because of the 'taboo' which still rests on disclosing in-prison substance abuse, especially for vulnerable sub-populations, there has been chosen to carry out a pilot study on cultural responsiveness within the specialized substance abuse treatment facilities in the clear-cut region of Gent.

Chapter 6 presents the general findings on motivation and readiness of incarcerated drug-involved criminal offenders towards substance abuse treatment. These figures are further differentiated on the basis of intellectual abilities and other client- and treatment-related variables. Implications for prison-based substance abuse treatment are elaborated, based on the reported empirical results.

In *chapter 7*, the results of a qualitative study using statements of incarcerated offenders, released detainees and rehabilitation services' staff members about (ex-)offenders' treatment needs and associated motivation to search for support and/or to engage oneself in treatment, are addressed.

Chapter 8 summarizes the previous chapters by providing a general overview and discussion of the main results. In conclusion, implications for clinical practice, methodological limitations of the study and directions for future research are included.

As the dissertation is an integrated compilation of self-contained – published, accepted and submitted – journal articles, some overlap between the chapters appeared to be inevitable. Moreover, as each of the articles has been written from the perspective to meet the aims and scope as well as the more editorial requirements of the different journals to the best of our ability, consistency in used terminology could not always be entirely guaranteed.

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CONTENTS

1

General Introduction

During the last decades, research and clinical attention for substance abusers with special needs has considerably grown, focusing on specific target groups such as women, elderly people, legally referred clients and prisoners, persons with another ethnical or cultural background, clients diagnosed with co-morbid psychiatric disorders, people with intellectual or physical disabilities and addicted mothers with children, amongst others (Broekaert, Vandevelde, Vanderplasschen, Soyez, & Poppe, 2002; Vandevelde, Vanderplasschen, & Broekaert, 2000). This heightened interest is not unexpected as a growing number of studies demonstrated that the efficiency and effectiveness of substance abuse treatment is distinctly associated with the special attention given to the specific needs of these subgroups amongst substance abusers (Lidz & Platt, 1995; Polinsky, Hser, & Grella, 1998). Furthermore, substance abuse treatment outcomes are related to quintessential concepts such as motivation, readiness and retention (De Leon, Melnick, & Hawke, 2000), which has been demonstrated for different populations and treatment settings (Joe, Simpson, & Broome, 1999). Therefore, it could be argued that a careful assessment of the special needs, support expectancies and motivation of substance abusers, rather than identifying them as a homogeneous group, could contribute to more effective treatment. The following theoretical paragraphs elaborate the before mentioned issues concerning incarcerated substance abusers with special intellectual needs, leading to a detailed overview of the global aims of this dissertation.

1.1. SUBSTANCE ABUSE IN CORRECTIONAL ESTABLISHMENTS: A THEORETICAL FRAMEWORK

1.1.1. SUBSTANCE ABUSE AS A BIO-PSYCHO-SOCIAL PROBLEM: DEFINITION AND APPLICATION WITHIN THE CRIMINAL JUSTICE AREA

A variety of different concepts has been applied to label people who are using or abusing (illicit) drugs, including drug addiction, problematic drug use, dependence, addictive behavior, alcoholism, substance use and abuse (Klaue, 1999; Robertson, 1998). These different labels reflect not only historical changes in attitude towards drug consumption; moreover their use is closely linked with etiological theories, crystallized in the contemporary 'adaptation vs. disease debate' (Klaue, 1999; Kooyman, 1993).

Attitudes towards drug use changed dramatically during the last decades. In the United States, opiate and cocaine use for instance became considered as extremely dangerous after a period of relative tolerance during the 1960s and 1970s (Klaue, 1999). A similar trend took place in different countries across Europe (Kooyman, 1993; Yates, 2002). The introduction of heroin in most European countries since the 1970s led to the development of new treatment modalities. These became gradually underpinned by spiritual, psychoanalytic, behavioral, system-oriented and social explanations (Kooyman, 1993; Miller, 2000). Since the 1980s, a disease model appeared, supported by biologically oriented theories, stressing the importance of physiology, health and genetic predispositions (Room, 1996). Later, social theories emerged: Zinberg (1992) and Yates (1999), amongst others, stress the importance of the relationship between drug use and the social environment, by which the drug (ab)user is often stigmatized. Nowadays, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM- IV) (American Psychiatric Association (APA), 1994) and the World Health Organisation's (World Health Organisation (WHO), 1992) International Statistical Classification of Diseases and Related Health Problems (ICD-10) offer up-to-date definitions of substance dependence and abuse. According to the DSM-IV (p. 181), dependence is described as a 'maladaptive pattern of substance use, characterized by three or more features occurring at any time in the same twelve-month period: tolerance, withdrawal, substance often longer taken than intended, a desire or unsuccessful efforts to control substance use, much time is invested in activities to obtain the substance, important social, occupational or recreational activities are given up and the substance use is continued despite the knowledge that physical/psychosocial problems have been caused or exacerbated by the substance'. In this definition, elements of the different previously mentioned

perspectives on substance abuse could be recognized, which is the result of the contemporary bio-psycho-social point of view.

This theoretical framework stresses the importance to take other interacting life areas and social factors into account when defining and assessing addictive behavior, instead of solely focusing on the abuse of substances (Brochu, Guyon, & Desjardins, 1999; Miller, 2000). The interrelations of substance abuse and social problems (Galea & Vlahov, 2002), criminal behavior (Deitch, Koutsenok, & Ruiz, 2000), health-related problems (Falck, Wang, Siegal, & Carlson, 2003) and psychological distress (Hiller, Knight, & Simpson, 1996), amongst other difficulties, have already been subject to a vast number of studies, highlighting mutual correlations and influences. More particularly, the effects of substance abuse on problems within the field of criminal justice have been widely demonstrated. Many substance abusers have committed criminal offences, which is for instance reflected by the increasing numbers of prisoners who are incarcerated for drug-related crimes, both in the United States as well as in Europe (Brochu et al., 1999). Quite some incoming prisoners identify the influence of drug use on the crimes they committed (Lo & Stephens, 2002). Substance users commit more violent crimes as compared to their non-drug using counterparts (Chaiken, 1986 in Sia, Dansereau, & Czuchry, 2000). A great part of prison inmates had been using substances at the time of the offence and/or committed the crime in order to obtain money for buying drugs (Lang & Belenko, 2000). Furthermore, substance abuse problems are associated with a life-style of criminality in general; a relationship which proves to be bi-directional: drug abuse leads to and is at the same time caused by engagement in criminal behavior (Newcomb, Galaif, & Carmona, 2001). Prisoners are more likely to be dependent on (intravenous) drug use as compared to the general population (Trace, 1998). Importantly, the relationship between crime and substance abuse holds true for persons in the criminal justice system, clinical (treatment) populations, adolescents and the general population (Newcomb et al., 2001).

1.1.2. SUBSTANCE ABUSE IN CORRECTIONAL ESTABLISHMENTS

Prison populations have been increasing un-proportionately during the last decades, certainly in the United States, where incarceration rates were up to three times as high at the end of the 1990s in comparison with prison statistics of 1980 (Lang & Belenko, 2000). Although cross-national data are extremely difficult to compare, the overpopulation within correctional establishments can be observed in many European countries as well (European Monitoring Centre for Drugs and

Drug Addiction - EMCDDA, 2003b), including Belgium (Meese, Van Impe, & De Ruyver, 2000). The number of prisoners in Europe is estimated to be over 350,000 (94/100,000 inhabitants) (EMCDDA, 2001b, 2003a). In the United States, the ratio is up to seven times higher (645/100,000) resulting in a total prison population of over 2 million detainees in the beginning of 2000 (EMCDDA, 2001b; Harrison, 2001). These figures represent the number of prisoners on any given day and they should therefore be multiplied by a turn-over rate coefficient, which could be estimated to be around 3 for Europe, in order to correctly interpret the statistics.

As it is already very difficult to estimate the number of (hidden) drug abusers in the community (Maxwell & Pullum, 2001), this is even more the case when it comes to investigating in-prison substance use and abuse, especially because of the taboo, which still surrounds the disclosure of illegal behavior in correctional establishments. Moreover, only a limited number of mostly ad-hoc and regional studies specifically tackled the prevalence of in-prison substance use, which makes it hard to draw definite conclusions (EMCDDA, 2003b; Plourde & Brochu, 2002).

Despite the efforts by the Belgian government to implement a wide range of measures to treat substance abusers rather than punishing them – as incarceration is considered as *ultimum remedium* (cf. 1.1.3) – substance abuse in prison, however, is still a serious problem. In Belgian correctional facilities, the number of substance abusers is estimated to be 33% to 42% of the entire incarcerated population (EMCDDA, 2001b). Yet, precise and comprehensive figures are not available, due to the hidden character of substance use in prison, mentioned above. A recent research project (De Maere, Hariga, Bartholeyns, & Vanderveken, 2000) in two Belgian correctional establishments indicated that 60% of the respondents declared having used substances during the month before incarceration and that 40% of the respondents also admitted having used illegal substances in prison (De Donder, 2001). In Belgian corrections, cannabis is most often used, followed by benzodiazepines, heroin and cocaine (BIRN, 2002). These tendencies seem to be in accordance with international, mostly American, figures, indicating that 70% of the newly arrested offenders show positive results for one or more illegal substances on a urine-analysis (Hiller, Knight & Simpson, 1999). Furthermore, some 65% of the current inmates have a history of regular illegal substance use (Simpson & Wexler, 1999). These high figures indicate that a substantial proportion of substance abusers are currently incarcerated (Martin, Butzin, Saum & Inciardi, 1999). The European Monitoring Centre for Drugs and Drug Addiction published statistics indicating that 15% to 50% of the prisoners in

the European Union are still actually having or have experienced problems with substance use (EMCDDA, 2003a). Muscat (2000) adds: '5% and a maximum of 70% of prison populations across Europe are made up of people who have used drugs and continue to do so while incarcerated'.

A recent study introduced the idea of a 'break' in the prisoner's substance abuse pathway when incarcerated, as many substance abusing inmates report changes with regard to the used substances, the frequency of and main motivations for use (Plourde & Brochu, 2002). This is underscored by current insights that some substance abusing offenders stop using when incarcerated, whilst other begin to use more intensively.
A not to be underestimated proportion of detainees (3% to 26%) even start using substances for the first time during incarceration (EMCDDA, 2003a). Again, cannabis is identified as the most popular drug. Although availability, price, difficulties and risks to obtain other drugs in prison could certainly be considered as reasons for the popularity of cannabis, Plourde & Brochu (2002) pointed out that inmates mainly use drugs in prison to relax, which is one of the main expected and pursued effects of cannabis.

To some extent, the wide range in the reported prevalence figures can be explained by the different definitions of drug use and abuse, currently used in European countries (EMCDDA, 2001b; Muscat, 2000). Moreover, only a limited number of countries keep systematic reports about the prevalence and nature of in-prison substance (ab)use, which impedes further comparisons between countries and more in-depth analyses of drug use trends within correctional establishments (EMCDDA, 2003a).

1.1.3. SOCIETAL REACTIONS TOWARDS (IN-PRISON) SUBSTANCE ABUSE

- THE BELGIAN DRUG POLICY FROM AN INTERNATIONAL PERSPECTIVE

Following the heroin and cocaine epidemics of the 1970s and 1980s, stringent anti-drug laws arose, primarily focusing on legal enforcement and punishment (Lang & Belenko, 2000). Although the already existing rehabilitation and treatment services continued to exist (cf. 1.1.1), a shift towards repressive action became clear, especially embodied within the American War on Drugs (Auerhahn, 2004) and policies of reprimand and penalization in a great part of Europe (EMCDDA, 2002).

However, in many European countries, the repression of (non-problematic) substance use, mostly involving cannabis, is no longer considered by the justice authorities as the only means to cope with drug problems (EMCDDA, 2001a). This evolution is underpinned by the implementation of extra-judicial alternative measures for substance abusers within the drug policies of several countries in the European Union (EMCDDA, 2001b). The three United Nations (UN) conventions of 1961, 1971 and 1988 identify additional and alternative measures besides repression and punishment as well (De Ruyver, Vermeulen, Vander Beken, Vander Laenen, & Geenens, 2002). In this respect, Dorn, Jepsen & Savona (1996, p. 1) state that 'in most member states of the European Union, a sharp escalation of the war on drug traffickers coexists with a reluctance to criminalize people simply for possessing or using illegal drugs'. In the line of these European trends, the Belgian drug policy identifies criminal justice interventions for drug users, often leading to imprisonment, as *ultimum remedium*, considering it as ultimate solution when other possible interventions have failed.

In 2001, the Belgian government published a federal document *'Beleidsnota van de Federale Regering in verband met de drugproblematiek'*, which outlines the most recent policy concerning production, trade and use of (illegal) drugs. It replaces the previous 80-year-old Narcotic Drug Act of 1921 (BIRN, 2003; Federale Regering, 2001). A normalization policy is proposed, specifically aiming at decreasing the number of substance abusers, drug-related physical, psychological and social harm and the negative consequences of drug abuse for society (BIRN, 2002, 2003). In order to accomplish these goals, the Belgian drug policy is based on three cornerstones: *prevention*, which is primarily aimed at people who are not (yet) using drugs and non-problematic users; *treatment, care, harm reduction and (re-)integration* for problematic substance abusers and *repression*, particularly targeted against drug producers and dealers. The Belgian policy should therefore be considered as an integrated, global approach, incorporating evaluation, epidemiology and research, promoting cooperation and partnerships on all levels. *Prevention* aims at discouraging people to use legal (as long as not for medical purposes) and illegal drugs. The Belgian government recognizes that substance abuse has always been and will (probably) always be a part of society. Instead of pursuing total abstinence in all cases, more realistic goals are put forward: increasing the age when people start using substances; tackling driving under influence of alcohol or drugs; decreasing and/or controlling use. Primary, secondary and tertiary prevention initiatives are used with a special focus on topics such as driving while intoxicated, smart drugs and psychoactive over-the-counter medicines. Furthermore, special attention is also given to prevention of specific vulnerable groups, including young

people, women and incarcerated substance abusers. *Treatment, care and harm reduction* are characterized by a wide variety of available services, ranging from low-threshold, harm reduction facilities and programs (such as needle-exchange) to high-threshold therapeutic services (such as therapeutic communities) (BIRN, 2002). Important challenges include the co-ordination of care (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002), the implementation of an unequivocal registration system and the cooperation between treatment services and the judicial system (Van Cauwenberghe, 2000). *Repression* is primarily targeted against producers and large-scale dealers. Producing, trading or trafficking drugs – of which the amount exceeds the notion 'for own consumption' – is tackled in a stringent and hard way (BIRN, 2002).

In principle, the Belgian drug policy tries to divert substance abusers, coming across the judicial authorities, to treatment services, instead of punishing them. This practice is based on recent scientific insights that substance abuse treatment is correlated with a decrease in criminal activity and recidivism (Belenko, 2001) (cf. 1.1.1) and the finding that treatment is less expensive than judicial sentencing, often followed by custody (Wild, Roberts, & Cooper, 2002). Therefore, the Belgian drug policy provides several measures, situated within each level of the judicial process, to tackle this diversion, including praetorian probation, release under conditions, probation and conditional release (Van Cauwenberghe, 2002).

❑ THE PROVISION OF PRISON-BASED TREATMENT

When identifying a strategy to tackle drug use in prison, it is interesting to determine the primary task of correctional establishments. An important issue within scientific literature about prisoners and criminal justice focuses on whether it is the role of corrections to punish or treat criminal offenders (McGuire, 2000; Torres, 1996). Martinson (1974), author of the well-known and influential article '*What works? Questions and answers about prison reform*', in which was essentially concluded that 'nothing works' in prison when it comes to rehabilitating people into society, reviewed his article and came to another - more optimistic – conclusion (Cullen & Applegate, 1997). Yet, also contemporary authors (Logan & Gaes, 1993) seem to defend the 'nothing works' literature. They primarily stress methodological shortcomings in the way of evaluating treatment and rehabilitation, pointing out that meta-analysis can be misused. They plead for a separation of treatment and punishment, stating: 'It is the duty of prisons to govern fairly and well within their own walls. It is not their duty to reform, rehabilitate, or reintegrate offenders into society'. Cullen and Applegate (1997, p.

xxviii) describe extensively the ongoing debate and conclude: 'At least in the U.S., rehabilitation represents the only competing philosophy that has the cultural roots and legitimacy among the public to provide a 'sensible' explanation as to why correctional interventions should invest resources in offenders'. Also Hollin (1999) points out that practitioners, researchers and administrators acknowledge again the importance of rehabilitating offenders, hereby stressing the 'what works' findings from meta-analysis; a point of view shared in this dissertation.

Comparable to treatment modalities in the community, prison-based treatment possibilities are diverse and comprehensive (EMCDDA, 2001b). In general, five distinct demand reduction treatment modalities targeted towards substance abuse are organized within correctional establishments: abstinence-oriented services (e.g. therapeutic communities); substitution treatment; detoxification; drug-free units and wings; and self-help groups.

Abstinence-oriented programs are amongst the most frequently organized treatment modalities in prisons across Europe. As much as 80% of the European member states organize prison-based drug-free programs (EMCDDA, 2001b). A not to be underestimated proportion of these services are in-prison therapeutic communities (TC) (Lipton, 1998), commonly traced back to two independent traditions: American concept-based hierarchical and European psychoanalytical democratic TCs (for an overview of definitions, methods, differences, similarities and mutual influences cf. Vandevelde & Broekaert, 2003). In Belgium, there is currently one suchlike facility, which operates according to concept-based therapeutic community lines, but five more units are planned to be operational in the future (EMCDDA, 2003b).

Substitution treatment, for instance using methadone, is a relatively new treatment option within European prisons. In Belgium, methadone prescription within correctional establishments is legally possible from 1995 on, albeit restricted by several conditions (BIRN, 2002). Generally, prison-based substitution treatment in Belgium is focused on reduction, whilst maintenance therapy is restricted for pregnant inmates, HIV-positive offenders and detainees with hepatitis as well as for those clients who already follow substitution treatment outside prison and whose sentence will not longer last than one year (BIRN, 2003).

Detoxification-services are available in almost all European member states, although substance abusers will be forced to undergo a *'cold turkey'* in several corrections. In Belgium, all new prisoners should be seen by a medical doctor at least within 48 hours after arrival. If they are receiving treatment or support from an external (substance abuse treatment) organization, this service will be contacted (BIRN, 2002).

Within drug-free units, specific treatment for substance abuse problems is offered (cf. therapeutic communities), while it is the objective of drug-free wings to offer an environment without drugs and substance use. Usually, drug-free units are characterized by living in group, with attention for a positive atmosphere and the power of the peers. Participants agree to follow treatment voluntarily and they promise to obey some basic rules, such as keeping the environment free of drugs. Sometimes, more formal control mechanisms (urine analysis) are used to enforce the clients to comply with these rules and regulations (EMCDDA, 2001b).
Self-help groups are organized in different countries as a means of treatment for prisoners and their family members.

Besides these demand reduction treatment programs, the following harm reduction services are organized in European prisons: vaccination programs (for instance against hepatitis B); providing disinfectant, including bleach, which can be used to clean injecting equipment; needle exchange programs and the provision of condoms (EMCDDA, 2001b). In Belgium, no vaccination nor needle exchange programs are organized within correctional establishments (EMCDDA, 2003b), although a new protocol for detecting infections was planned to be operational in 2004 (BIRN, 2003).

Finally, the following services, focusing on restoring the relationship with the wider community, can be distinguished: preparation for release; through- and aftercare; family services; continuity of care (cf. transitional care); individual counseling; and treatment services for ex-prisoners (EMCDDA, 2001b). Community links are also pursued by cooperation and networking activities between external service providers and criminal justice actors (BIRN, 2003).

1.2 CRIMINAL OFFENDING (INCARCERATED) SUBSTANCE ABUSERS WITH SPECIAL INTELLECTUAL NEEDS

A growing body of research pointed out that adolescents and adults with special intellectual needs are experiencing elevated risks with regard to substance abuse (Snow, Wallace, & Munro, 2001) and criminal offending, particularly in the light of social disadvantages (Holland, Clare, & Mukhopadhyay, 2002). Yet, these reported findings remain ambiguous, due to methodological differences across studies (Lindsay, 2002). These difficulties include the wide range of used definitions on intellectual disability. In this dissertation, special (intellectual) needs are described as intellectual disabilities characterized by significant limitations both

in intellectual functioning and in adaptive behavior, expressed in conceptual, social and practical adaptive skills (based on the definition of the American Association on Mental Retardation (AAMR), 2002). Using a suchlike definition, we aim at including those persons who could be situated in the gray zone between normally achieving persons and their counterparts with intellectual disabilities. Although these clients often experience difficulties related to their specific intellectual needs, they are not always formally recognized. Consequently, some authors described this important sub-population as the '*forgotten generation*', because their needs, which are very similar if not the same as those clients formally defined as having intellectual disabilities, are not taken into account (Tymchuk, Lakin, & Luckasson, 2001). Therefore, the assessment of special intellectual needs should be situated within five inter-related domains: intellectual abilities; adaptive behavior; participation, interaction and social roles; health; and context, indicating the importance of the client's unique support needs.

Because of normalization, de-institutionalization and inclusion tendencies (Van Loon & Van Hove, 2001), more and more people with intellectual disabilities live in the community nowadays, which has besides numerous advantages, some negative consequences as well. Besides low employment rates, financial burdens, problems with social network members and the lack of social support, faced by many independently living persons with intellectual disabilities (Cocco & Harper, 2002a), these also include the aforementioned elevated risks of exposure to harmful substance use and anti-social behavior (Christian & Poling, 1997; Glaser & Deane, 1999; McGillivray & Moore, 2001; Westermeyer, Kemp, & Nugent, 1996). Not surprisingly, most of the clients on whom these findings are applicable, fall in the range of people with mild to high moderate intellectual disabilities (Edgerton, 1986; Westermeyer et al., 1996), since they more often live in the community, compared to people with severe intellectual disabilities.

1.2.1. CRIMINAL OFFENDING BY PEOPLE WITH SPECIAL INTELLECTUAL NEEDS

In the beginning of the nineteenth century, under influence of the American 'Eugenics' movement, people with intellectual disabilities were considered as determined to a life of criminality and offending. Perhaps the most well-known example in this respect is Goddard's (1912) book on the Kallikak family (stemming from the Greek 'kalos'-beautiful and 'kakos'-bad), investigating the heredity of so-called 'feeble-mindedness' (Holland et al., 2002). Since the end of World War II, these ideas of predestination were abandoned under the impetus

of normalization insights (Glaser & Deane, 1999) and other theory-driven concepts such as emancipation, empowerment and self-determination (Van Loon & Van Hove, 2001). Nowadays, the relationship between criminal offending and people with intellectual disabilities is viewed upon as a much more complex phenomenon, incorporating concepts such as 'mens rea', that is the deliberate and well-considered intention linked with a crime. Holland et al. (2002, p. 9, [ ] brackets by author) state: 'Within services for people with ID [intellectual disabilities], informal judgements are frequently made that one or more ingredients is missing (e.g. because the person did not know that the act was illegal, or was not aware of the possibility that harm would result , …)'. Recently, a number of studies investigated criminal offending in populations with intellectual disabilities (Glaser & Deane, 1999; Holland et al., 2002; Turner, 2000). Persons with intellectual disabilities are more at risk to get caught by the police and to lose their way within the complex judicial structures. In addition, the following personal attributes are usually applicable: poor, uneducated, unemployed, young, socially deprived and male, showing histories of behavioral problems and of criminal records in the social network.

In conclusion, although it is difficult to present exact figures on the presence of persons with intellectual disabilities within the different stages of the justice system due to methodological, geographical, cultural and other difficulties, we can assume that people with intellectual disabilities are represented in all levels of the criminal justice system (Holland et al., 2002).

1.2.2. SUBSTANCE ABUSE BY PERSONS WITH SPECIAL INTELLECTUAL NEEDS

Although there has been reported on some earlier research, several studies focused specifically on substance (ab)use by persons with intellectual disabilities since the 1980s. The research findings of those studies have been reviewed and summarized in recent papers, illustrating the heightened interest in the topic (Burgard, Donohue, Azrin, & Teichner, 2000; Cocco & Harper, 2002b). Although difficult to estimate, alcohol and substance use rates of people with intellectual disabilities are considered to be the same or somewhat lower as compared to statistics of the general population (Edgerton, 1986; Krishef & DiNitto, 1981; Westermeyer et al., 1996). Cocco & Harper (2002a) pointed out that persons with special intellectual needs have different expectancies from substance use and display different use patterns, for instance resulting in binging episodes. Available recent research (Westermeyer, 1999) indicated that persons with special intellectual needs begin using substances later, display fewer substance abuse-

related disorders, but, if they do, experience more severe problems, leading to treatment within a shorter period of time as compared to their counterparts in the general population. The reasons of why people with special intellectual needs use both legal and illicit substances seem to be different to a certain degree from those persons with disabilities. Studies in adolescent samples pointed out that people with intellectual disabilities report using substances because they do not want to be different than their counterparts without disabilities, who use drugs mainly for pleasure (Cocco & Harper, 2002a). Research in adult populations also revealed incentives as 'fitting in and feeling accepted' as well as 'overcoming loneliness' (Wenc, 1980-1981). Yet, consistent with findings in the general population, 'pleasure', 'stress relief' and 'being included' are also mentioned as potential reasons (Degenhardt, 2000). Moreover, as many persons with special intellectual needs experience social limitations, for instance characterized by impaired communication skills, which could lead to isolation, social attention seeking could be considered as the most important reason of substance (particularly alcohol) use (Christian & Poling, 1997).

Up until now, little research has investigated treatment outcomes of clients with intellectual disabilities (Burgard et al., 2000). Paxon (1995, p. 167) even describes persons with special intellectual needs as one of the most 'underserved populations' within substance abuse treatment. More clinical attention and related scientific studies are needed, examining the access of clients with special intellectual needs in generic substance abuse treatment services (Lottman, 1993), the effects of social skills enhancement strategies (McGillicuddy & Blane, 1999), the assessment of and client matching to the most applicable type of treatment and the implementation of potential modifications to existing treatment modalities, amongst other research topics (Paxon, 1995).

1.2.3. SUBSTANCE ABUSE IN CRIMINAL OFFENDERS WITH SPECIAL INTELLECTUAL NEEDS

By our knowledge and with the exception of some regional studies, for instance in Australia, the relation between drug problems and criminal offending in persons with special intellectual needs has been subject to only one study published in a peer-reviewed journal, indexed within the Social Sciences Citation Index (*ISI Web of Science*). McGillivray & Moore (2001) compared the prevalence of and knowledge about alcohol and illicit drugs between offending adults with mild intellectual disabilities and a matched sample of non-offending counterparts. They concluded that the offenders with special intellectual needs used more and

larger quantities of both legal and illicit substances than the comparison group. Furthermore, over 50% of the former participants declared being under influence when committing the crime. This result, suggesting a potential link between substance abuse and engagement within the criminal justice system, is consistent with other research in the general population (Lo & Stephens, 2002) and within samples of non-offending clients with intellectual disabilities (Krishef & DiNitto, 1981). A questionnaire, testing the knowledge of persons with intellectual disabilities about drugs, indicated that many participants did not adequately comprehend the consequences of substance use on both themselves and society, including criminal justice authorities (McGillivray & Moore, 2001). This result is in accordance with the observations, made by Holland et al. (2002) about the negative implications of anti-social behavior in general. Given this overall lack of insight into the effects of drug use, offenders with intellectual disabilities scored significantly better than the non-offending comparison group. According to McGillivray & Moore (2001), the results of the study imply that specific prevention programs should be designed for people with special intellectual needs (for a comprehensive review on prevention and drug education for clients with special intellectual needs, cf. Snow et al., 2001). Moreover, specifically tailored treatment services, tackling substance abuse problems at the onset from a holistic perspective, could prevent a further escalation of substance abuse and engagement in criminal behavior (Hope, James, & Yoder, 1999).

1.3. MOTIVATION AND READINESS TOWARDS SUBSTANCE ABUSE TREATMENT

1.3.1. MOTIVATION TO CHANGE AND READINESS TO TREATMENT

A vast number of studies indicated that motivation for change and readiness towards treatment have an important effect on retention, client engagement and success in substance abuse treatment (Broome, Knight, Knight, Hiller, & Simpson, 1997; De Leon, Melnick, Kressel, & Jainchill, 1994; De Leon, Melnick, Thomas, Kressel, & Wexler, 2000; Hiller, Knight, Leukefeld, & Simpson, 2002; Joe, Simpson, & Broome, 1998; Sia et al., 2000). Although both concepts have much in common, as they each address a different end within the same more general change process, it is quintessential to differentiate the broader motivation to change from readiness to treatment, which is characterized by a well-considered commitment to actively participate in treatment (Hiller et al., 2002). Over time, both concepts of motivation and treatment readiness went through an evolution

from being regarded as static personality characteristics, predisposing something you have or do not have, towards the current view of dynamic, continuous and fluctuating variables (De Leon, Melnick, & Hawke, 2000; DiClemente, 1999; Prochaska, DiClemente, & Norcross, 1992; Serin & Kennedy, 1997). As an important consequence, motivational attributes can be modified and enhanced. According to Miller (2000), different incentives should be distinguished which could potentially prompt the start of a suchlike process: stressful events and crisis-situations such as 'hitting bottom' (De Leon, Melnick, & Hawke, 2000); important life events (pregnancy, marriage, the loss of social network members, etc.) (cf. Curry, McBride, Grothaus, Lando, & Pirie, 2001); cognitive evaluations and contemplation (DiClemente, 1999); the recognition of negative consequences (Battjes, Gordon, O'Grady, Kinlock, & Carswell, 2003) and positive as well as negative external incentives, including social support (Soyez, 2004) and coercive treatment (Farabee, Prendergast, & Anglin, 1998). Furthermore, motivation is influenced by demographic variables, including age, and substance abuse severity (Melnick, De Leon, Hawke, Jainchill, & Kressel, 1997; Rapp, Li, Siegal, & DeLiberty, 2003).

Research pointed out that motivation positively effects especially short-term treatment outcomes (DiClemente, 1999), although more long-term lasting effects are reported as well (De Leon, Melnick, & Kressel, 1997; Melnick et al., 1997). According to DiClemente (1999) this difficulty of predicting long-term outcomes could be partially attributed to the difference between extrinsic and more intrinsic motivation.

Extrinsic motivation is related to external pressures, perceived by the individual as beyond its control. The majority of research within this respect focused on legal pressure, leading to mandated or coerced treatment. Recent data obtained within the framework of a registration study in the province of East-Flanders, Belgium (Vanderplasschen, Colpaert, Lievens, & Broekaert, 2003), illustrated that about one fifth of all clients has been referred to treatment by police or judicial authorities (Vandevelde & Vanderplasschen, 2003). As international research indicated even higher percentages, up to 70%, clinical and research attention is not unexpected (Grichting, Uchtenhagen, & Rehm, 2002; Lurigio, 2002). Results showed that legally referred clients are equally or even more likely to complete treatment as compared to their 'voluntary' counterparts (Anglin & Hser, 1991; Anglin, Prendergast, & Farabee, 1998; Grichting et al., 2002). Yet, due to methodological and theoretical variances, research on the effectiveness of coerced

treatment has led to equivocal results (cf. Wild et al., 2002) and further research is definitely needed (Vandevelde & Vanderplasschen, 2003).

Intrinsic motivation on the other hand is attributed to internal reasons for personal change (De Leon, 1996). Some studies demonstrated that intrinsic motivation is more related to lasting behavior change than extrinsic motivation (Curry, Wagner, & Grothaus, 1990), which underscores the importance of acknowledging the individual's personal and inner pressures (De Leon, Melnick, & Hawke, 2000; Miller, 2000). Other research pointed out that motivation is not only the key to initiate change (Miller, 2000) but that it also plays an important role during the whole treatment process (Joe et al., 1998; Wexler, De Leon, Thomson, Kressel, & Peters, 1999). Numerous studies in different treatment modalities (Joe et al., 1999) have illustrated that the impact of those dynamic variables on retention and success is more outspoken than the influence of fixed, socio-demographic variables such as gender or age (Condelli & De Leon, 1993; Joe et al., 1998). Moreover, the findings that motivation and readiness are linked with treatment outcome, is demonstrated within several sub-populations, such as drug-using criminal offenders (Melnick, De Leon, Thomas, Kressel, & Wexler, 2001) and clients in mandated substance abuse treatment (Hiller et al., 2002) (cf. 1.3.3).

1.3.2. THEORETICAL MODELS

Several theoretical models have been put forward to clarify the issues of motivation and readiness in substance abuse treatment. One of the most applied is the transtheoretical model, developed by Prochaska and Diclemente (Prochaska et al., 1992), identifying five phases: pre-contemplation, contemplation, preparation, action and stabilization. These phases are circularly linked, which explains why clients usually pass through (a part of) the model more than once. The transtheoretical model is not only applicable within treatment settings, as some studies empirically underpinned a comparable process within natural recovery, i.e. behavior change using no or only very limited professional assistance (Miller, 2000). De Leon (1996) explicitly connected the transtheoretical model to substance abuse treatment, distinguishing six pre-treatment phases: denial, ambivalence, motivation (extrinsic), motivation (intrinsic), readiness for change and readiness for treatment a well as four treatment related phases: deaddiction, abstinence, continuance and integration and identity change. Based on this ten stage recovery-oriented paradigm, De Leon and colleagues developed an instrument to measure motivation and readiness towards substance abuse

treatment: the Circumstances, Motivation, Readiness and Suitability Scales (CMRS) in order to investigate the components of the underlying motivational model (De Leon et al., 1994). Based on the 42-item version of the CMRS-scales, a shortened instrument was constructed using factor analysis on data from a wide variety of client samples in therapeutic communities, drug-free out-patient facilities and substitution treatment: the Circumstances, Motivation and Readiness Scales (CMR), containing 18 items. Moreover, data on special populations, including criminal justice clients, were also used in these analyses (De Leon, Melnick, & Hawke, 2000). Studies using the CMR(S)-scales on data of clients treated in therapeutic communities (De Leon et al., 1994), adolescents (Melnick et al., 1997), different groups of clients indicating diverse drugs as most frequently used substance (De Leon et al., 1997), ethnically diverse substance abusers (De Leon, Melnick, Schoket, & Jainchill, 1993) and incarcerated substance abusers admitted in prison-based TCs (De Leon, Melnick, Thomas et al., 2000), showed linear relationships between CMR(S)-scores and variables related to (short-term) retention.

1.3.3. MOTIVATION IN CLIENTS WITH SPECIAL NEEDS

Several authors raised important questions as to whether or not the before mentioned findings, for the greater part based on research in community settings, could be generalized to the criminal justice field in general and prison-based treatment programs more in particular (De Leon, Melnick, & Hawke, 2000; Hiller, Knight, & Simpson, 1999). Consistent with the findings in community-based services, the earliest results indicated a relationship between pre-treatment motivation and outcome, albeit indirectly. Motivation proved to predict entry in post-prison aftercare treatment, which is related to a decrease in the likelihood of relapse into substance abuse or criminal recidivism (Wexler et al., 1999). More recent studies further underscored that motivation is also related to therapeutic engagement in prison-based treatment programs (Hiller et al., 2002). Yet, admissions in prison-based TCs display lower motivational scores, measured by the CMR-scales, than their counterparts in regular therapeutic communities and TCs for specific sub-populations, such as mentally ill and homeless substance abusers (De Leon, Melnick, & Hawke, 2000). These results are supported to a certain degree by other research in the criminal justice field, which indicated that incarcerated addicted offenders are less motivated to change than their (offending) counterparts following substance abuse treatment (Brochu et al., 1999) and that criminal justice-referred clients are less motivated than non-justice-referred substance abusers (Farabee, Nelson, & Spence, 1993). Furthermore, some

researchers (Polcin, 1999) pointed out that judicial clients, mandated to substance abuse treatment, are often still pre-contemplators whereas many of their non-judicial counterparts have already made some progress in the transtheoretical cycle. A potential reason for the difference in levels of motivation between incarcerated offenders and their counterparts residing in the community is the presence of 'non-recovery incentives for entering treatment that are more related to (avoiding or concluding) incarceration than to drug use' (De Leon, Melnick, & Hawke, 2000, p. 120, brackets by author). Moreover, research pointed out that incarceration could cause a break in the substance abuse pattern (Plourde & Brochu, 2002) (cf. 1.1.2), leading some inmates to stop or diminish their use and/or to start using other specific substances (particularly cannabis) more frequently than before incarceration, which could temporarily influence their motivational levels. Such forms of situational recovery are usually not resulting in long-term lasting effects, however. As soon as the original situation has been restored, substance use patterns often return to their former extent (DiClemente, 1999; Miller, 2000). It seems that besides behavioral processes, cognitive decisions are extremely important within suchlike unintentional 'spontaneous' attempts of behavior change (DiClemente, 1999).

The transtheoretical model of Prochaska and DiClemente, as well as the ten stages recovery-oriented paradigm by De Leon, rest – for a great part – upon the cognitive abilities of the clients themselves, who have to recognize the need for help, evaluate pros and cons of behavior change and develop a plan of action (Blume, Davis, & Schmaling, 1999). In addition, the evolution from extrinsic towards intrinsic motivation could be partially explained by cognitive processes, as individuals have to attribute substance abuse and associated problems to inner reasons instead of external incentives. This obliges them to critically evaluate positive and negative perceptions about themselves, necessarily involving in-depth intellectual activity (De Leon, 1996; DiClemente, 1999). In this respect, Blume et al. (1999, pp. 112-113), who investigated the motivation of dually diagnosed patients with neurocognitive dysfunctions, stated: 'Motivation to change behavior involves using complex cognitive abilities, including observational processes, reasoning, flexibility, planning and memory. Such cognitive skills are crucial for successful behavior change'. They concluded that dually diagnosed clients who displayed more difficulties with general reasoning, abstract thinking and problem solving – impairments experienced by persons with mild or borderline intellectual disabilities – showed lower treatment readiness. Hence, neurocognitive functioning seems to be a mediating factor of motivation to change behavior, related to substance abuse. However, these results should be interpreted with

caution, because of the small sample and the specific target group of the study (Blume et al., 1999). Another research project specifically tackled the relationship between retention and cognitive deficits, including problems with abstract reasoning and problem-solving, in a therapeutic community (Fals-Stewart & Schafer, 1992). A significant relationship was demonstrated between intellectual functioning and the length of time spent in the program. Participants displaying low scores on relevant subtests of the Wechsler Adult Intelligence Scale (WAIS) showed significant lower retention rates, as compared to those clients with average or high WAIS-scores. Since the before mentioned cognitive skills are extremely important during the first phase of treatment, because clients have to internalize many new treatment demands, a lack of exactly those proficiencies could provoke confusion between motivation and comprehension of treatment expectancies. In other words, client problems in understanding what is expected during treatment could be misunderstood by treatment staff as a lack of motivation, leading to premature drop-out, if not addressed properly (Fals-Stewart & Schafer, 1992). Up until now, no published large-scale studies were carried out concerning the assessment of motivation in intellectually disabled offenders. Yet, one pilot study investigated if motivational enhancement techniques, based on Prochaska and DiClemente's transtheoretical model, could be effectively used for alcohol abusing offenders with intellectual disabilities (Mendel & Hipkins, 2002). The results pointed out that a specifically tailored, even limited, motivational enhancement strategy (three group sessions of one hour, spread over a two-week period) successfully increased motivation to change alcohol abuse-related behavior for six of the seven participants in the group. Again, due to the small, not randomized sample, drawn from one correctional facility, the reported results should be interpreted cautiously.

In conclusion, growing scientific evidence showed that intellectual abilities are related to motivation and treatment readiness, which led us to further explore some promising avenues within this area of substance abuse research.

1.4. MAIN GOALS OF THE DISSERTATION

1.4.1. AIMS OF THE STUDY

An exploratory literature review using international scientific databases (including *ISI Web of Science*, *PsycINFO* and *MEDLINE*), preceding the actual studies which constitute this dissertation, revealed a heightened clinical and

research interest in (the effects and outcomes of) substance abuse treatment for legally referred clients and incarcerated criminal offenders, amidst other special target groups. A further, more thorough, exploration of the specific Belgian situation in this respect, learned us that (in-prison) substance abuse had only been the subject of a limited number of studies within the criminal justice system. Therefore, the idea to organize a piloting research project in several correctional settings in Belgium gradually took shape. As it further turned out that the existing prison-based interventions in Belgium to tackle substance abuse are rather limited, we chose to focus our attention on a non-treatment sample of drug-involved criminal offenders. Moreover, an additional rationale for this decision could be attributed to the fact that special attention should be given to those inmates for whom a prison sentence does not seem to be in the best interest of both society and the individual concerned, especially in times when correctional establishments are continuously overcrowded. This is particularly true for specific sub-groups of prisoners, such as substance abusers, mentally ill detainees and people with intellectual disabilities, who – from our point of view – would benefit more from treatment than from a prison sentence. The results of a second, more focused, literature study, highlighted the importance of motivation and readiness within prison-based substance abuse treatment and the potential correlations between intellectual abilities and motivational indices, which led to the conceptualization of the main research questions. Hence, this dissertation primarily aimed to investigate the differences between drug-involved offenders with and without special intellectual needs, particularly with regard to quintessential treatment-related characteristics, including motivation and readiness towards substance abuse treatment in (prison-based) therapeutic communities and other treatment modalities.

The global aim of the study is subdivided in three related objectives, each of which specifically tackles one aspect of the dissertation's main goal.

First of all, we wanted to investigate current tendencies in the provision of prison-based substance abuse treatment. As therapeutic communities are commonly described as the most widely organized in-prison treatment modalities, we chose to focus on this specific treatment method. Only a little number of studies tackled the development of and current tendencies within the TC in correctional establishments up until now, despite the wide availability and promising outcome results of many prison-based TCs.
Secondly, we aimed at mapping the client characteristics of drug-involved criminal offenders, incarcerated in Belgian prisons. Because of our interest in the

relationship between intelligence and motivation, we were specifically interested in exploring the intellectual abilities of this population, as well as potential differences between clients with special intellectual needs and their counterparts without. As the available literature, suggesting the effect of cognitive functioning on motivation and treatment effectiveness is rather limited and – by our knowledge – up until now only situated within specific client populations, such as dually diagnosed substance abusers, more studies tackling the before mentioned goals could contribute important information. Besides these characteristics, we also took cultural differences into account, as a not to be underestimated proportion of the research population could be described as ethnically and/or culturally diverse.

Thirdly, we wanted to assess the motivation and readiness of incarcerated substance abusers towards substance abuse treatment, as well as the associated treatment and support needs. A related goal consisted of investigating potential differences between clients with special intellectual needs and their counterparts without intellectual disabilities. To our knowledge, this is the first, albeit limited pilot study, which specifically addresses a suchlike research question.

1.4.2. RATIONALE BEHIND THE GLOBAL PURPOSE

The rationale to specifically focus on these three objectives primarily related to the current situation in Belgium concerning substance abuse treatment and linked research within the criminal justice field. Although the provision of prison-based treatment is certainly recognized as a priority within European drug policies, there still seem to be considerable shortcomings regarding the availability of treatment and prevention initiatives in several prison systems (EMCDDA, 2001b). In Belgium, recognizable tendencies could be observed, although promising pilot projects have been recently set up or are scheduled for the near future (EMCDDA, 2003b) (cf. 1.1.3). One of these projects for instance resulted in the development of a prison-based central intake initiative [*Centraal Aanmeldingspunt*], aiming at the provision of coordinated and continuous treatment (through-care) for incarcerated substance abusers during the sentence and upon release (BIRN, 2003). Because of the current clinical and scientific interest in the provision of treatment and prevention in the criminal justice field in general and in correctional establishments more in particular, we chose to elaborate this topic as a first research question in the present dissertation.

Furthermore, recent studies highlighted the importance to tailor treatment interventions towards specific needs of special target groups among (incarcerated)

substance abusers (Lidz & Platt, 1995; Polinsky, Hser, & Grella, 1998), including people with special intellectual needs, ethnically diverse clients, dually diagnosed persons, etc. Up until now however, almost no studies looked into these topics within the specific Belgian context, although we may assume that the same subgroups, identified by international research, could be differentiated. Therefore, we aimed at investigating characteristics of two special target groups. First of all, we were interested in exploring the cognitive abilities of (drug-involved) criminal offenders, as recent studies showed potential interrelationships between treatment success (with major attention on motivational indices) and intellectual functioning (Blume, Davis, & Schmaling, 1999). Since the majority of studies in this field, target people labeled as mentally retarded (Cocco & Harper, 2002a, 2002b; McGillicuddy & Blane, 1999; McGillivray & Moore, 2001), we focused on this special sub-population in one study. Secondly, ethnically diverse clients were retained as another target group of interest. Although the popular media often report on topics related to cultural differences, substance use and abuse by ethnically and culturally diverse populations has not yet been extensively studied, especially not in Belgium. Important research questions in these studies include the definition and classification of special target groups; the potential differences between those clients and their counterparts without these special features; and potential implications for treatment. Due to the exploratory nature of the dissertation, the research groups were broad, in order to grasp the totality of the current situation. This should lead to more focused studies in the future, tackling well-defined research questions.

Based on a review of current literature on substance abuse treatment, motivation to change and readiness towards substance abuse treatment could be identified as reliable predictors of treatment success (Hiller & Simpson, 1997; De Leon, Melnick, Kressel, & Jainchill, 1994: Joe, Simpson, & Broome, 1998) (cf. 1.3). Again, only a limited number of studies investigated the concept of motivation and readiness of substance abusers in the Belgian context (cf. Soyez, De Leon, Rosseel, & Broekaert, submitted). By our knowledge, no studies, mapping the motivation of drug-involved incarcerated Belgian offenders, were published in international journals up until now. Although we could assume that the results would be congruent with international data (cf. De Leon, Melnick, & Hawke, 2000), research was definitely needed to explore this question. Moreover, the link between intellectual abilities and motivation, which had already been demonstrated for some client populations (Blume, Davis, & Schmaling, 1999; Mendel & Hipkins, 2002), was not yet examined in the Belgian context.

In conclusion, the research topics could be summarized as *(1)* the provision of prison-based treatment, focusing on therapeutic communities in correctional establishments; *(2)* the (treatment-related) characteristics of special target groups focusing on special intellectual needs and ethical and/or cultural origin; and *(3)* the motivation of incarcerated offenders and its potential relationship with cognitive abilities.

Although it would undoubtedly have been very interesting to investigate these main questions in the framework of the before mentioned ongoing pilot projects in Belgium, this was impeded because of several reasons. First of all, the available (internationally) published scientific data regarding the nature of substance abuse in Belgian prisons and the main characteristics of drug-involved offenders proved to be very limited. This obliged us to tackle these issues, before we could investigate the actual topics of this dissertation (motivation and readiness). Secondly, also practical difficulties (including lack of time and resources) hampered the exploration, development and evaluation of modifications to existing treatment initiatives for drug-involved criminal offenders, especially for those clients with special intellectual needs. As treatment places in general are already sparse, special target groups are certainly underserved in the current context. Moreover, the existing treatment initiatives have been developed recently or are still in the planning phase (EMCDDA, 2003b). A third reason for the rather descriptive character of the dissertation relates to the nature of the research in general. As the studies, conducted in the framework of this dissertation, are exploratory (due to the lack of similar preceding studies in Belgium) the pilot results should be interpreted with caution. The main findings cannot be generalized without further research, especially not to other cultural contexts. Therefore, this dissertation aimed at highlighting some potential ways for future studies, which should primarily investigate the implications for treatment initiatives. From that point of view, the dissertation should be considered as a first, but essential step towards the development, implementation and evaluation of appropriate treatment (modifications) for incarcerated criminal offenders with and without special (intellectual) needs.

1.4.3. STRUCTURE OF THE DISSERTATION

The three objectives of the dissertation were tackled by means of six separate studies (each representing a chapter), which could be clustered in three sets of two related research projects, each corresponding with one of the three research questions, described above.

The first cluster of studies focused on current tendencies within the provision of substance abuse treatment in correctional establishments. Generally, prison-based demand-reduction initiatives can be differentiated as *(1)* abstinence-oriented facilities, including therapeutic communities; *(2)* substitution treatment; *(3)* detoxification; *(4)* drug-free units & wings; and *(5)* self-help groups (cf. 1.1.3). Abstinence-oriented programs are amongst the most frequently organized treatment modalities in European prisons, as 80% of the European member states organize prison-based drug-free programs. Since a not to be underestimated proportion of these services are in-prison therapeutic communities, we chose to focus our attention on this specific treatment modality. We are aware that it would have been meaningful to investigate the particular treatment initiatives in Belgian prisons. Yet, due to the fact that only one prison-based TC-like facility is currently operational in Belgian correctional establishments, although more units are planned in the near future, we tackled our first objective by means of a historical comparative review of the two main types of prison-based therapeutic communities: the American hierarchical drug-free concept-based TC (modeled on Synanon) and the European democratic Maxwell Jones-type TC, identifying current tendencies of in-prison TCs (*chapter 2*).
Based on the results of this literature review, an empirical N=1 study was carried out which focused on one of the most important current attributes of the prison-based TC, i.e. the confrontational encounter group and the evolution of this method into a less harsh conversation, based on dialogue and mutual respect. Because the one prison-based TC in Belgium has only been operational for a relatively short time, and since it does not make use of encounter groups, we chose to plan this study within a concept-based therapeutic community outside correctional establishments, since the core attributes of both prison-based TCs and TCs outside the correctional system are identical (*chapter 3*).

The second cluster of studies explored the characteristics of incarcerated drug-involved offenders. As we have illustrated in the theoretical section of this introduction, researchers have recently demonstrated that there are links between intellectual abilities and motivation to change drug related behavior (cf. Mendel & Hipkins, 2002). Because the main goal of this dissertation focuses on mapping the motivation to change and readiness to start substance abuse treatment in a sample of incarcerated offenders with special (intellectual) needs, we aimed at looking into the connection between intellectual abilities and motivational attributes more into detail. This seemed especially relevant as previous (international) research (see e.g. Koeter & Luhrman, 1998) already showed that a great part of incarcerated offenders display low scores on intelligence tests. Based on these findings, it could

potentially be argued that low motivation figures in criminal justice clients, often reported in international studies (cf. 1.3.3), are related to the difficulties in intellectual functioning.

A first step in our dissertation with regard to this second objective, comprised of investigating whether or not clients with special intellectual needs differed from their counterparts without special needs. Congruent with international research, we classified people on basis of the most recent definition of the *American Association on Mental Retardation* (AAMR, 2002). According to the AAMR (2002), intellectual disabilities are characterized by limitations both in intellectual functioning and in (conceptual, social and practical) adaptive skills. However, some difficulties arose when applying the AAMR classification system. First of all, the administration of a comprehensive intelligence test (such as the *Wechsler Adult Intelligence Scale,* WAIS) was contra-indicated as too time-consuming and not really suited for ethnically diverse clients. Therefore, the *Raven Standard Progressive Matrices* (SPM) (Raven, Court, & Raven, 1998) were used. Besides the fact that this test highly correlates with the WAIS (O'Leary, Rusch, & Guastello, 1991), other positive features include the short administration time and the non-verbal test design.

A second, more fundamental, difficulty concerning the application of the AAMR system, was the lack of appropriate assessment instruments and procedures to measure adaptive behavior skills in the subpopulation of drug-involved incarcerated offenders. The assessment of adaptive behavior should be broad, targeting several life domains, which is not self-evident in controlled environments. Therefore, we aimed at integrating findings from other instruments, in order to enlarge our classification method, initially solely based on the Raven SPM-scores. As the EuropASI, the European version of the Addiction Severity Index (Kokkevi, Hartgers, Blanken, Fahner, Tempesta, & Uchtenhagen, 1993) contains questions on seven life domains, corresponding with the adaptive skills areas set forth in the AAMR definition, we integrated these data in our classification protocol. An additional rationale for this procedure, is the assumption that both disability research and substance abuse research have gone through a comparable evolution from a disorder-oriented (medical) paradigm, towards a more ecological, context-oriented point of view. This enabled us to compare persons labeled as intellectually impaired with their counterparts without disabilities, on the specific adaptive skill areas mentioned in the AAMR classification system. In order to do so, an empirical pilot study was carried out in the correctional establishments of Brugge, Gent, Leuven & Merksplas,

investigating the differences between people labeled as intellectually impaired and those without intellectual disabilities (*chapter 4*).
Furthermore, we have already pointed out that a not to be underestimated proportion of prison inmates have another ethnical and/or cultural origin. Besides taking this into account when choosing the most appropriate assessment instruments (e.g. the Raven SPM as against the WAIS), we also specifically aimed at inventorying treatment-related characteristics of ethnically diverse clients. Again, our study should be considered as an exploratory research project, highlighting some promising ways for future research. Therefore, we looked into the cultural responsiveness of substance abuse treatment facilities, based on qualitative statements by both clients and representatives of service providers. Due to the fact that this proved to be difficult with prison settings, especially because of the taboo which still rests on in-prison substance use, particularly for ethnically/culturally diverse clients, and the fact that treatment is often not available within corrections into the same extent as compared to the 'outside' community, the study was situated in the clear-cut region of Gent, where a representative sample of substance abuse treatment services participated in the research project (*chapter 5*).

The before mentioned clusters aimed at increasing insight in topics related to substance abuse treatment in correctional establishments. Besides throwing light on a specific treatment modality (therapeutic communities) and the application in criminal justice settings, the target group of drug-involved criminal offenders was characterized. In this respect, major attention was given to important attributes: intellectual functioning and cultural responsiveness.

The last cluster of studies goes into the main topic of the dissertation and assessed the motivation and readiness towards treatment, the associated treatment and support needs and the relationship between intelligence and motivational indices in a sample of incarcerated drug-involved offenders. An empirical pilot study was carried out identifying three groups of drug-involved offenders: low, moderately and highly intelligent participants. Results concerning differences between these three research groups with regard to motivational indices are presented and implications for treatment are discussed (*chapter 6*).
Treatment and support needs as well as motivation were investigated by means of qualitative research on statements by incarcerated drug-involved offenders, recently released detainees and representatives from service providers. We focused on four main questions: what are the most important problems incarcerated and recently released drug-involved offenders struggle with; which are their main

treatment and/or support needs; what is the importance of prison-based treatment and how motivated are people to enter prison-based treatment facilities *(chapter 7)*?

Although the different successive studies are broad and diverse, they all relate to the main goal set forth in this dissertation: mapping the motivation of drug-involved criminal offenders with special intellectual needs. Since this area has not yet been extensively studied within the Belgian context, many questions still remain unanswered. This dissertation aimed to be a first essential step towards gaining more insight in the complex relation between intellectual functioning and motivational indices. Future research should focus on well-identified issues, such as the evaluation of potential treatment modifications or specific approaches for incarcerated offenders with special intellectual needs, in order to further build on and expand the pilot findings reported in the present research.

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2

The Development of the Therapeutic Community in Correctional Establishments:

A comparative retrospective account of the 'democratic' Maxwell Jones TC and the 'hierarchical' concept-based TC in prison [1]

The correction-based therapeutic community (TC) is one of the most described treatment modalities for (substance abusing) incarcerated offenders. The origins and development of the therapeutic community have been traced back to two independent traditions: the American hierarchical concept-based TC and the British democratic Maxwell Jones-type TC. Both branches have developed independently, targeting different people and tackling diverse problems. The study aims at demonstrating that there are clear and undeniable similarities between the 'two' prison-based therapeutic communities, by means of a comparative historical review of the literature and a critical discussion and comparison. The links between the democratic and hierarchical therapeutic communities are summarized under five headings: social learning and behavioral modification; permissiveness and modeling; democracy and hierarchy; communalism and community as method; reality testing and 'acting as if'. It is concluded that the 'two' correction-based therapeutic communities are on converging pathways. Far from being oppositional models, they can be regarded as being complementary.

[1] This chapter is based on: Vandevelde, S., Broekaert, E., Yates, R., & Kooyman, M. (2004). The development of the therapeutic community in correctional establishments: a comparative retrospective account of the 'democratic' Maxwell Jones TC and the 'hierarchical' concept-based TC in prison. *International Journal of Social Psychiatry, 50*(1), 66-79.

2.1. INTRODUCTION

The correction-based therapeutic community (TC) is a widely described treatment modality for (substance abusing) offenders (Hiller, Knight, & Simpson, 1999; Lurigio, 2000). Its origins can be traced back to two major independent traditions: the American drug-free hierarchical concept-based TC and the British democratic Maxwell Jones-type TC (Broekaert, Vanderplasschen, Temmerman, Ottenberg, & Kaplan, 2000; De Leon, 2000; Kennard, 1998a; Lipton, 1998b; Rawlings, 1999b). The hierarchical approach was modeled on Synanon, founded by Charles Dederich (Bratter, Collabolletta, Fossbender, Pennachia, & Rubel, 1985; Yablonsky, 1965). It developed as a self-help movement for the treatment of substance abusers, primarily using behavioral modification techniques. The democratic approach is most commonly associated with Maxwell Jones. It developed as a professional group work method to treat people suffering from a range of psychiatric difficulties, primarily using social learning principles (Jones, 1952, 1968). In this chapter, a comparative historical account of the 'two' correction-based therapeutic communities will be presented, identifying similarities in both movements.

2.2. THE DEMOCRATIC TC AND ITS APPLICATION IN PRISON

2.2.1. THE DEMOCRATIC TC

The democratic TC is described by Clark (1977, p. 554) as 'a small face-to-face residential community using social analysis as its main tool'. Its origins can be traced back to (1) the Northfield Experiments (Hollymoor Hospital, Northfield [Birmingham], 1942 – 1948), which can be considered as one of the first attempts to rehabilitate people (neurotic soldiers) by means of the 'therapeutic use of groups' (Harrison & Clark, 1992, p. 698) and (2) some experimental treatment units during and just after World War II (Mill Hill and Dartford, London) for neurotic soldiers and ex-prisoners of war, initiated by Maxwell Jones (Jones, 1952). Jones is commonly referred to as the 'father' of the democratic therapeutic community (Clark, 1965, 1977; Kennard 1998a; Murto, 1991a, 1991b).

Jones formulated the axioms of his work as follows: (1) two-way communication on all levels; (2) decision-making on all levels; (3) shared (multiple) leadership; (4) consensus in decision-making; and (5) social learning by interaction in the 'here and now' (Jones, 1968, 1982). Social learning could be described as Socratic learning (see e.g. Roszak, 1978), in which the facilitator simply helps the

participants to uncover the knowledge from within the group, rather than introducing new knowledge through teaching. Rapoport (1960) described the democratic TC as having four central principles:

Permissiveness: residents can freely express their thoughts and emotions without any negative repercussions (in the sense of punishment or censure).

Democracy: all residents and staff members have equal chances and opportunities to participate in the organization of the TC.

Communalism: face to face communication and free interaction to create a feeling of sharing and belonging.

Reality testing: residents can be, and should be, continually confronted with their own image (and the consequent impact of that) as perceived by other clients and staff members.

2.2.2. THE DEMOCRATIC TC IN PRISON

During the early 1950s, Scudder (1952) – then superintendent of Chino prison in California, U.S.A. – was one of the first to acknowledge the importance of a humanistic approach towards prisoners. His book '*Prisoners are people'*, paved the way for implementation of transitional therapeutic communities (see Briggs, 2000). During this same period, Richard McGee, the administrator of Youth and Adult Corrections in California, was initiating a wide scale reform of state prisons. One major reform involved a thorough evaluation and screening of inmates (residents) in a Reception-Guidance Centre, from which they were allocated to the most suitable facility (Jones, 1962). During this process, a 'base expectancy' score, implemented as a predictor of recidivism (parole violation) (Jones, 1962, p. 79), was calculated for each prisoner along with a social maturity rating (Sullivan, Grant, & Grant, 1957). Grant and Grant (1959, p. 127) wrote: 'Seven successive stages of interpersonal maturity characterize psychological development. They range from the least mature, which resembles the interpersonal interactions of a newborn infant, to an ideal of social maturity which is seldom or never reached in our present culture'. These so-called I-levels (levels of interpersonal maturity) were used to identify to what degree residents were able to form relationships and to predict how they might respond to treatment. Jones (1962, p. 81) wrote: 'This is an interesting attempt to introduce a classification system which promises to be more appropriate for a prison population than any psychiatric classification yet devised.'

In 1959, Jones accepted an invitation to become a visiting professor in social psychiatry at Stanford University in California (U.S.A.). He presented five lectures at the annual meeting of the American Psychiatric Association, which were published in the book *'Social psychiatry in the community, in hospitals and in prisons'* (1962). In the fourth lecture, Jones discussed 'social psychiatry in prisons'. Following this appointment, Jones was appointed to the Oregon State Hospital in Salem (Oregon), where he facilitated the establishment of therapeutic community principles. In the early 1960s, the Department of Corrections in California (in person of Richard McGee) invited Jones to work as a consultant for the next four years, giving advice on pilot projects using therapeutic community principles in prison settings (Briggs, 2000; Jones, 1976). One such project was piloted at a 100-man unit based in a forestry camp, whilst another was a unit for 50 inmates at the California Institution for Men, the prison located at Chino. Elias, one of the directors of the Highfields Project for juvenile delinquents (McCorkle, Elias, & Bixby, 1958), also worked as a consultant on these initiatives. Briggs has written several accounts on these projects (see Briggs, 1972, 1980, 2001). At this time also, Harry Wilmer had established a therapeutic community in San Quentin Prison which, in addition to its program for inmates, offered extensive group treatment for wives and children (Briggs, 2000; Wilmer, 1965, 1966). All together, 11 prison projects, using democratic therapeutic community principles, were developed (Jones, 1962, 1979b; Roberts, 1997). The targeted population varied from older prisoners to substance abusers and women (Briggs, personal communication - 2001). In Southern California, the California Rehabilitation Center (C.R.C.) was built and operated by the Department of Corrections. The staff members were trained according to therapeutic community principles and both Maxwell Jones and Harry Wilmer were employed as consultants.

During the 1970s, Miller, the director of Massachusetts' Youth Correctional Agency, introduced the Guided Group Interaction (G.G.I.) model as an alternative to incarcerating young people in prison (Briggs, 1975).

In this initiative by Miller, Maxwell Jones trained the staff alongside a former resident of a prison therapeutic community. The success of this project led to the closure of all the state prisons for juvenile offenders who were subsequently treated in non-custodial facilities. As a result, programs for young offenders were developed in California, using a combination of G.G.I and therapeutic community procedures (Palmer, 1971; Studt, Messinger, & Palmer, 1968). Despite their success, most of these innovative programs were terminated during the 1970s on grounds of cost-effectiveness. In addition to the Californian projects, similar programs were established in New York (the 'Network Project'), in Arizona and at

the Springhill Correctional Facility in Canada. Maxwell Jones was employed as consultant for all these initiatives.

Elsewhere, these American democratic therapeutic community experiments (established under the direct or indirect influence of Jones), inspired several democratic TC-based programs for offenders within the United Kingdom during the 1960s. HMP (Her Majesty's Prison) Grendon (established in 1962) is probably the most noted example and, unlike other therapeutic communities (such as the Barlinnie Special Unit in Scotland), still exists. Yet, even there, a constant struggle between two opposing goals (treatment vs. imprisonment) has been and continues to be a central characteristic (Cullen, 1997; Rawlings, 1999a; Roberts, 1997). Several prisons were also changed towards more open systems in other European countries, including the Netherlands (Van der Hoeven Clinic, Utrecht), Denmark (Herstedvester) and Switzerland (Champdollon Prison, Geneva) (Genders & Player, 1995; Jones, 1979a).

2.3. THE CONCEPT-BASED TC AND ITS APPLICATION IN PRISON

2.3.1. THE CONCEPT-BASED TC

A concept-based therapeutic community is 'a drug-free environment in which people with addictive problems live together in an organized and structured way to promote change toward a drug-free life in the outside community. Every TC has to strive towards integration into the larger society; it has to offer its residents a sufficiently long stay in treatment; both staff and residents should be open to challenge and to questions; ex-addicts can be of significant importance as role models; staff must respect ethical standards, and TCs should regularly review their reason of existence' (Broekaert, Kooyman, & Ottenberg, 1998, p. 595). The hierarchical TC was modeled on Synanon, a dynamic group work living initiative founded by Charles Dederich in 1958. Within six years of its founding, Synanon had both encouraged the establishment of a small but influential group of 'successor' TCs and been responsible for a schism which remained unresolved until Dederich's death. There were several reasons for the divide, which developed between Synanon and the organizations, which adopted and adapted its work. In addition to Dederich's autocratic and increasingly erratic leadership, there was the 'forced' lifelong commitment to Synanon, the lack of contact with the outside world and resistance to research and evaluation, the absence of professional help and the often harsh and extreme learning experiences and disciplinary techniques

(O'Brien, 1993). The value system of the concept-based TC includes early Christian values (Broekaert & Van der Straten, 1997; Glaser, 1977; Mowrer, 1976), the 'first century Christian fellowship' and the Oxford group of F. Buchman (Lean, 1985), Alcoholics Anonymous (Yablonsky, 1965), the Synanon philosophy (Garfield, 1978) and the humanistic psychology of authors such as Maslow (Maslow, 1967) and Rogers (Bugental, 1967). The essential elements of the American hierarchical drug-free therapeutic community are extensively described by De Leon (2000). Most crucial is the concept of 'community as method', which stresses the 'purposive use of the peer community to facilitate social and psychological change in individuals' (De Leon, 1997, p. 5). Parallel to the characteristics of the democratic TC, the following principles can be summarized:

Community: living together in a group and showing responsible concern and belonging is the main agent for therapeutic change and social learning.

Hierarchy: daily activities take place in a structured setting, where people 'act as if' they have no problems and where 'older' residents serve as role models.

Confrontation: negative behavior, which interferes with the community concepts, values and philosophy is confronted and put to limit. During confrontations in encounter groups all feelings can freely and openly be expressed.

Self help: the resident is the protagonist of his own treatment process. Other group members can only act as facilitators.

2.3.2. THE CONCEPT-BASED TC IN PRISON

Despite hostility from the prison system authorities (Gates & Bourdette, 1975) and an initial failure at the Federal Prison of Terminal Island in California in the beginning of the 1960s, a Synanon-inspired initiative was established at Nevada State Prison in 1962. Prisoners in maximum security (total isolation) were permitted to leave their cells to attend Synanon sessions. By attending Synanon activities they could move into the general prison population; to special cell blocks (Synanon tiers of 25 inmates); to Synanon's Peavine Honor Camp (isolated facilities of 20 men outside of prison) or they could be paroled directly to Synanon facilities (Yablonsky, 1965). Almost in spite of itself, Synanon began to develop positive relationships with the criminal justice penal system.

A value-based project with a hierarchical structure and 'games' was subsequently set up at the Federal Penitentiary at Terminal Island and at the San Francisco County Jail in San Bruno, California. At the end of the 1960s, an initiative named

'Asklepieion' (after the Greek God of healing) was established in the Federal Prison at Marion (Illinois, U.S.A.) by the psychiatrist, Martin Groder. Groder was deeply influenced by both Synanon (see Gates & Bourdette, 1975) and Eric Berne (see e.g. Berne, 1972) who had developed the transactional analysis model. The original Asklepieion TC was short-lived (it closed in 1978), but it remained an influence for many other concept-based therapeutic communities in prisons, such as Terminal Island (California), Oxford (Wisconsin), Stillwater (Minnesota) and Ft. Grant (Arizona) (Bartollas, 1981). Further prison-based concept therapeutic communities were developed in Danburry, Connecticut, and New York's Green Haven Prison (Lockwood, Inciardi, Butzin, & Hooper, 1997).

This brief flourishing of the TC model within prisons lasted until the early 1970s, when it began to lose momentum and several programs had to close, although others continued for many years. The Stay 'n Out prison TC program was established (in 1977) at New York in two prisons (Arthur Kill Correctional Facility for men on Staten Island and Bayview Correctional Facility for women in Manhattan) and it was primarily based on the Phoenix House model (Rawlings, 1999a; Wexler, 1997). Outcome studies, (based upon reincarceration rate of inmates who successfully completed the program) appeared to confirm the success of this initiative and identified the Stay 'n Out program as an effective method of treatment (Wexler, Blackmore, & Lipton, 1991). Around the same period (1976), another therapeutic community (Cornerstone) for substance abusing offenders (although not situated within a prison) was developed at the Oregon State Hospital in Salem. Here too, positive results were reported in evaluation studies (Field, 1989; Lipton, 1994). Some other prison-based therapeutic communities were developed between the 1970s and the mid-1980s, focusing primarily on substance abusers, but also on sex offenders and mentally ill residents (Lipton, 1998a). Interest in prison-based therapeutic communities was rekindled in the 1990s when their success was recorded in several outcome studies.

Several authors (Hiller et al., 1999; Lees, Manning, & Rawlings, 1999; Rawlings 1999a) give an overview of the positive results of programs such as KEY-CREST, Delaware (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997; Inciardi, Martin, & Surratt, 2001; Martin & Butzin, 1999; Martin, Butzin, & Inciardi, 1995), Amity TC at R. J. Donovan California State Prison (Wexler, 1997; Wexler, De Leon, Thomas, Kressel, & Peters, 1999), Kyle New Vision, Texas (Knight, Hiller, & Simpson 1999) and IMPACT (Lurigio, 2000; Swartz, Lurigio, & Slomka, 1996). The increase in drug-free programs in prisons is also observable in the European Union (Turnbull & Webster, 1998). In a recent overview study by the European

Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2001), abstinence-oriented treatment programs (such as the TC) are identified as the dominant treatment initiative in European corrections.

To a certain degree, all concept-based TC in prisons are based on self-help principles. Understanding and compassion is combined with discipline and hierarchy. Life is structured on the basis of clear and consistent rules. Increased authority and esteem can be gained by a corresponding increase in responsible behavior. Feelings are expressed during emotional encounter groups. Learning takes place through peer-group interaction. Experienced staff and ex-substance abusers function as role models. Values such as self-discipline, non-violence, acceptance of authority and guidance, honesty and openness are encouraged. Acceptance of limitations and earning of privileges leads gradually to integration into society (Glider, Mullen, Herbst, Davis, & Fleishman, 1997; Wexler, 1995).

2.4. THE TWO THERAPEUTIC COMMUNITIES

The two movements were developed quite independently (Rawlings & Yates, 2001), although early pioneers within both movements must undoubtedly have known each other's work to some degree. Briggs (1993, p. 32) reports on a meeting that took place between Charles Dederich and Maxwell Jones in the beginning of the 1960s (when Jones was a visiting professor in social psychiatry at Stanford University, California) in the grounds of Synanon: 'Max was especially interested in the use of 'games' and their general approach with addicts. Most of all, he wanted to exchange views with the founder, who now was becoming well known'. It is interesting that neither individual had tried to approach the other of their own volition. And yet both movements had not only coined with the same name, but also obviously shared several characteristics (such as working with groups). Briggs (1993, p. 33) again provides more insight: 'Max, who now had become very critical of the programs, surprised me: instead of enquiry, he was telling the founder about his own approach and - not very subtly - suggesting how he would change Synanon. This encounter of course was disastrous – the two exchanged few further words and the meeting was over.' This quotation appears to suggest that Jones felt Synanon was too autocratic and confrontational, compared to its own method and way of implementing social change. In the absence of any formal record of this (or any subsequent) meeting between the two, the 'clash' between these two charismatic personalities can only be imagined. Exploration (by the authors) of the Synanon Foundation Records (1956 – 1987),

stored in the archives at UCLA (Department of Special Collections) has not thus far revealed a reference to the meeting between Dederich and Jones. Further, Rod Mullen (Chief Operating Officer, Amity Foundation) & Naya Arbiter (Principal, Extensions, LLC), contacted Dr. Lewis Yablonsky, who could neither confirm the encounter nor give additional information.

Accounts written by contemporaries make it clear that even at this early stage of Synanon, the autocratic leader, Dederich was extremely reluctant to countenance any contradiction (Jackson, 1997). Indeed, he even refused confrontations or challenges during the 'games' and the older he became, the more he developed into the unapproachable leader. Miriam Bourdette (in Yee, 1997), a house friend reports: 'I do feel he became very paranoid and more authoritarian than he had been in the earlier days of the Synanon'.

In later years, after the concept-based TC developed independently from Synanon and expressed its obligations to existentialism and the humanistic psychology, Jones actively tried to connect both traditions and became one of the most prominent advocates for integration (Jones, 1979a, 1984a, 1984b). He was an enthusiastic supporter of developments at Asklepieion, despite its reliance upon the confrontational techniques (the 'game', which was often harsh and 'violent') of Synanon (Gates & Bourdette, 1975). He was not, however, afraid to voice his reservations and even when the programs was adjusted to become more 'caring', Jones (1979a, p. 145) noted: 'The drug-free therapeutic communities and the Asklepieion model in prison, use the power of the peer group in a way that to many people seems more persuasive and even threatening than therapeutic'.

At a weeklong workshop of practitioners and theorists, Jones listed twenty-one principles for a therapeutic community in prison (Jones, 1980, p. 39) noting that: '…it is probable that Asklepieion method may have advantages for certain 'hardened' clients and the model I espouse may suit better the more sensitive, short-term inmates.' He called for the establishment of 'viable models' of therapeutic communities for demonstration and training staff.
During the 1970s, Jones was frequently invited to address conferences of the drug free therapeutic communities where he developed respectful friendships with such concept-based TC proponents as De Leon and Ottenberg. At these meetings, he found a forum to express his ideas; on one occasion, acting as a consultant for a TC for substance abusers in Rome (Centro Italiano di Solidarietà – CeIS), where he tried to 'integrate' the two communities. In this initiative he was joined by other democratic TC proponents such as Dennie Briggs and Harold Bridger (Vandevelde & Broekaert, 2003). Jones has, in addition, written several accounts

(published in American addiction journals) in which he comments on the possible integration (Jones, 1979a, 1984a, 1984b).

Today, the principle of social learning is fully accepted in the concept-based TC. De Leon (2000, p. 70) quotes Jones: 'In TC all learning occurs through social interactions, experiences and roles.' He continues: 'This assumption is the basis for using community itself as primary teacher. In the TC, learning is experiential, occurring through participation and action; a socially responsible role is acquired by acting the role'. Jones was always accepting of the concept-based therapeutic community, even noting that (1984a, p. 25): 'It is evident that the programmatic TC does an infinitely better job for someone who is addicted to drugs that any democratic TC could achieve' (see also Kooyman, 1993).

2.5. LINKS BETWEEN DEMOCRATIC AND HIERARCHICAL TCS IN PRISON

2.5.1. SOCIAL LEARNING AND BEHAVIORAL MODIFICATION

The hierarchical TC is generally characterized by a behaviorally oriented approach. However, the democratic TC approach is to some extent also behaviorally oriented, certainly within the strict and authoritarian regimen of the prison setting (Genders & Player, 1995). In '*Grendon: a study of a therapeutic prison*', Genders and Player (1995, p. 81) argue that: 'The therapeutic community regime incorporates a strong behavioral component, whereby an individual's actions are examined with surgical precision and commented upon by the whole community.' Winship (2001, cited in Frye, 2001) concluded that, in the UK, hierarchy is found in democratic therapeutic communities and vice versa. The hierarchical TC recognizes social learning as one of its pivotal concepts today (Broekaert et al., 1998; Broekaert, van der Straten, D'Oosterlinck, & Kooyman, 1999) and, according to Genders & Player (1995), 'social learning' in the democratic TC can be a hard and confronting process because it does not always portray a person the way he would like to be seen.

2.5.2. PERMISSIVENESS AND MODELLING

In a democratic prison-based TC, permissiveness provides prisoners with greater freedom to act out, without consequent disciplinary action. Yet, this does not mean that everything is tolerated. Instead of being punished, the resident is

confronted by his peers and by staff with regard to the effects of his behavior on them (the community). Talking about misbehavior in public (generally within the community meeting) is often perceived by the residents as more difficult than punishment (Rapoport & Rapoport, 1959).
Genders and Player (1995, p. 196) perceive permissiveness as a facilitating principle within the process of disclosing honestly personal feelings: 'The sense of security which is engendered by the avowed commitment to treatment objectives, and by the belief that the expression of deviant attitudes and behavior will not automatically attract a formal disciplinary response, entices inmates to display, conduct and divulge information that they would otherwise suppress in a conventional prison'.

In a hierarchical prison-based TC, negative behavior is confronted freely and openly in groups. After catharsis and openness, which can be part of a painful process, older residents identify with the expressed problems, serve as role models and encourage 'right living' (De Leon, 2000). This includes certain shared assumptions, beliefs, and precepts that constitute an ideology or view of healthy personal and social living. This could be described as a deliberate imposition of roles on residents in a top-down attempt to influence instinctive behavior.

2.5.3. DEMOCRACY AND HIERARCHY

Democracy is often associated with freedom and responsible action. The important far-reaching difference between a staff member (who is actually 'free' to go home after duty) and the residents (who must remain) is undeniable. Although participation in the therapeutic community is voluntary at all times, giving the resident the freedom and the responsibility to quit the program at any time, the broader context of imprisonment (and often coercive treatment) limits absolute freedom of decision. Briggs (2000) points out that the distance between staff members and residents is often so delicately narrow that it requires continuous re-evaluation of mutual roles. In a hierarchically structured prison TC, freedom and responsibilities are expressed by position in the structure. In this context, older residents have more freedom. But there is also the prison framework and the confrontation with the 'absolute' freedom of the staff. To counter this problem, an adequate social and therapeutic climate of mutual understanding is crucial. Rawlings (1999a, p. 179) writes: 'For the maintenance of therapeutic integrity in both types of therapeutic community, it is thought best if they are isolated as much as possible from the anti-social prison culture, and enabled to create their own alternative community'.

2.5.4. COMMUNALISM AND COMMUNITY AS METHOD

Within a prison-based therapeutic community, 'communalism' and 'community as method' refer to a climate and atmosphere in which the community as a whole is used as a therapeutic force. Here, residents function as main agents of their own treatment process. 'Self -help' can be considered as the main therapeutic tool. Briggs (1963) states in the article: 'Convicted felons as social therapists' that properly treated and trained residents can help themselves and others not only within a therapeutic community, but also outside its 'safe' borders (in the larger community). Graduates of hierarchical therapeutic communities remain a family, continually support each other, promote a drug-free life and try to be role models to more junior residents. Thus, an ideological surplus is added to the therapeutic community, as the therapeutic community can be perceived as a treatment modality *an sich* as well as an ideology to decrease social inequity generally (Kennard, 1998a). Communalism and community as method can pose specific problems in correctional facilities. It is not always possible to react appropriately to behavior according to the TC-methodology, where positive behavior is rewarded by privileges (Farabee et al., 1999). Security regulations are seen as paramount and can impede a community-driven action. Wexler (1997) points out that therapeutic communities within prisons can only be successfully implemented when security issues are accepted as fundamental task of corrections. Also Briggs (2000) writes about the tension between security issues and community decisions. He stresses the importance of establishing borders, which cannot be crossed without endangering the therapeutic community (Briggs, 2000).

2.5.5. REALITY TESTING AND ACTING AS IF

Reality testing addresses the inherent confrontation and contradiction between self-image and peer perception (Rapoport, 1960). One could describe this characteristic as being a true mirror for everyone, whilst at the same time, one's own image is mirrored by the other members. Each resident is given the freedom to be himself/herself and is subject to commentary and responsible concern. Within the drug-free therapeutic community, the mirror of confrontation is also determined by a concept and value system. The internal motivation and acceptance of the drug-free TC belief system follows a period of behavioral and external motivation (De Leon, 2000). During daily activities the resident has to act as if he has no problems. The tensions built up by acting like this can be released during group sessions. The often harsh and emotionally hard encounter groups,

sometimes broke not only the image of the resident but damaged his personality structure (Bracke, 1996) because he had to act as if he internally changed but did not do so willingly. The current knowledge of this phenomenon (especially in Europe under the influence of professionalism and psychoanalytic traditions) explains the current evolution of the encounter into dialogue (cf. chapter 3 - Broekaert, Vandevelde, Schuyten, Erauw, & Bracke, 2004).

2.6. DISCUSSION OF THE SIMILARITIES AND DIFFERENCES

Recent literature emphasizes a gradual, but not to be underestimated, tendency towards integration (Broekaert et al., 2000), stressing the common features of the American hierarchical drug-free ('new') and the English 'Jones' or democratic ('old') therapeutic community. Several authors (Broekaert et al., 2000; De Leon, 2000; Jones, 1979a, 1984a; Kennard, 1998a; Sugarman, 1984; Wilson, 1978; Zimmer & Widmer, 1981; see also Lees, Manning & Rawlings, 1999) have stressed the existence of fundamental similarities and have remarked upon the growing relations between both TC-'traditions'. Jones (1979a, p. 147) has written: 'It could be said that all the therapeutic communities described, both 'old' and 'new', have certain trends in common. All subscribe to the power of the client peer group … all started as residential communities … all claim to espouse a democratic social organization and democratic ideals … all avoid the extreme professionalism … '. Cox (1998) reminds us that certain concepts and practices that Maxwell Jones developed still have relevance in contemporary community psychiatry: respect for the client's integrity, the unique role of residents as well as staff, and a distinct type of leadership with provisions to check the abuse of power (Jones, 1982). These elements would seem to be essential in both types of therapeutic community. The similarities between the two types of therapeutic communities are summarized by Lees, Manning and Rawlings (1999). Both types are essentially democratic; the concept-based TC is applied to other target groups (such as prisoners – see De Leon, 2000); both types address somewhat different ends in the treatment process: the concept-based TC is designed primarily for behavioral change, whereas the democratic TC is essentially focused on further social maturation and personality change (see Jones, 1984a). In this sense, far from being oppositional, they could be regarded as being complementary.

Some other similarities might be added: (1) social learning is the key-concept within both types (see Broekaert, van der Straten, D'Oosterlinck, & Kooyman, 1999); (2) confrontation (originating in Synanon as 'the game') within concept-

based TC is evolving towards more dialogue, stressing the importance of equal and free communication within both approaches (see Broekaert et al., 2001); (3) both types of therapeutic communities (especially within corrections) are considered appropriate by the prison authorities, at least for those residents who have some motivation to change (see Kennard, 1998b); (4) motivation to treatment is identified as a crucial concept (see De Leon, Melnick, Thomas, Kressel, & Wexler, 2000), especially with regard to post-prison aftercare (post-prison aftercare is considered extremely important in both types of therapeutic communities) (see De Leon et al., 2000; Robertson & Gunn, 1987); (5) the challenges faced by both traditions are similar and both types struggle with the employment of staff members, the treatment versus security dilemma and both approaches are challenged by recent developments in the delivery of managed care.

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3

Evolution of Encounter Group Methods in Therapeutic Communities for Substance Abusers [2]

Some literature indicates an evolution in the concept underlying therapeutic communities (for substance abusers), where encounter group methods evolved from harsh confrontation to dialogue and discussion. The literally transcribed proceedings of two similar encounter groups, held at a 20 year interval, were systematically analyzed on four main variables: direction of communication sequences and associated behavior, emotions and attitudes of all participants (staff members, 'older' and 'newer' residents). In general, 'towards' and 'back' messages are relatively more balanced in the 'new' encounter (2000), as compared to the 'old' encounter (1980). Furthermore, associated behavior in the 'new' encounter is found to be more supportive, whereas ventilated emotions are more negative than in the 'old' encounter. The number of communication units within the 'old' and 'new' encounter, characterizing a positive or negative attitude, seems to have remained stable over the years. These findings support the reported evolution in encounter groups, where the focus has moved from mutual confrontation towards balanced and respectful dialogue.

[2] This chapter is based on: Broekaert, E., Vandevelde, S., Schuyten, G., Erauw, K., & Bracke, R. (2004). Evolution of encounter group methods in therapeutic communities for substance abusers. *Addictive Behaviors, 29*(2), 231-244.

3.1. INTRODUCTION

The drug-free hierarchical therapeutic community (TC) originated at Synanon (Broekaert, 1999; Broekaert, Vanderplasschen, Temmerman, Ottenberg, & Kaplan, 2000; O'Brien, 1993). The concept incorporates early Christian values (Glaser, 1977; Mowrer 1976), the Oxford Group (Moral Rearmament) of F. Buchman (Lean, 1985), Alcoholics Anonymous (Bassin, 1977) and 'the Synanon philosophy' (Garfield, 1978). Though grounded in a tradition of behaviorism (De Leon, 1974), the TC was influenced by the American humanist wave in psychology and by several important leaders including Maslow (1967), the promoter of the 'third way in psychology', Rogers (1961), the developer of the 'client-centered therapy', and Casriel (1976), the initiator of 'the new identity process'. They all visited or commented on Synanon.

Over the years, the classic TC evolved into a 'new' one (Broekaert, Kooyman, & Ottenberg, 1998).

In the 1970s, families of residents became directly involved. Influential family therapists such as Kaufman (Kaufman, 1979) and Stanton (Stanton, 1985) initiated a more individual approach to the needs of residents and their families. A family approach, such as the contextual therapy of Boszormenyi-Nagy (Boszormenyi-Nagy & Krasner, 1986) was an essential part of Buber's tradition which is based on dialogue (Buber, 1970). In Europe, Picchi and Corelli (Picchi, 1994) contributed to the change from behaviorism to existential humanism. Influenced by Moreno (Moreno, 1914, 1967) and Frankl (Frankl, 1963), they stimulated the rapprochment between the therapeutic community for substance abusers and the European democratic TC (Jones, 1984).

From the 1990s, the evolution was characterized by an expanding vision which sought to include new target groups (such as adolescents, psychiatric patients, homeless people, ethnically and culturally diverse clients, prisoners, people using substitute drugs (e.g. methadone), etc.) and by an enlarged methodology (De Leon, 1997). Professionals assumed the responsibilities of ex-substance abusers, and researchers gradually gained admittance (Broekaert, van der Straten, D' Oosterlinck, & Kooyman, 1999).

The recent evolution towards managed care and new economic thinking have forced therapeutic communities into the development of 'Integrated and Comprehensive Treatment Systems'. 'New Management'-initiatives demand flexibility, interaction and dialogue between the different model units and therapeutic functions (De Leon, 1996).

Some – often 'gray' – literature point to an ongoing evolution in encounter group methods from one of harsh confrontation to one of dialogue and discussion (Bracke, 1996; Poulopoulos, 1995; Shankman, 1994; Van der Meer, 1997).

The encounter is the primary therapeutic tool of the concept, drug-free, hierarchical therapeutic community (Bratter, Collabolleta, Fossbender, Pennachia, & Rubel, 1985; Kooyman, 1992; Nash, 1974). In Synanon, the encounter group was commonly referred to as 'the Game' (Dederich, 1973). It was seen as 'an uninhibited conversation, an arena for discussing all human feelings, community issues and the relationships among people' (Garfield, 1978, p. 8). 'There is usually a brief silence, a scanning appraisal as to that is present, and a kind of sizing one another up. Then, the group launches into an intense emotional exchange of personal as well as collective problems. A key point of the sessions is the emphasis laid on extreme uncompromising candor about one another. No holds or statements are barred from the group effort at truth seeking about problem situations, feelings and emotions of each member of the group (…) This often left them with a clearer view and a greater knowledge of their inner and outer world' (Acampora & Stern, 1994, p. 3). To a certain degree the encounter group formed a behaviorist reaction to psychoanalysis. It was felt that psychoanalysis, whilst providing insight, failed to change negative behavior (Bratter et al., 1985, pp. 461-507). Consequently, encounter groups in TCs for substance abusers should be distinguished from groups in European democratic TCs – who were mainly influenced by psychoanalysis (Bridger, 1984) – as well as from the 'Encounter Group Movement' (T(raining)-, and Sensitivity Groups) of the 1970s (Lieberman, Yalom, & Miles, 1973), which were less confrontational.

The encounter methods were often described (Ames, 1976; Broekaert, 2001; De Leon, 2000; Kooyman, 1992; Sugarman, 1974). Confrontation with one's behavior is an essential aspect. Experienced group members ('older' residents) have a lot of 'tools' at their disposal such as humor, exaggeration, contradiction, acceptance and support. Newer residents have not fully acquired these group skills yet. Consequently, older residents act as examples for the newer ones and can be considered as real role models (cf. De Leon, 2000).

Confrontation is mostly direct and takes place in 'the here and now' of a given situation. It leads to open emotional expression and acceptance of positive values through identification and role modeling. Positive values can be defined as in accordance with the value system of the TC, referring to common human feelings (such as showing respect, support, acceptance, etc.), which are generally considered as constructive and valuable. Although having certain emotions

cannot be considered as negative *in se*, the expression of certain feelings can be regarded at as opposite to the value system of the TC. Being irritated, cynical, mocking, etc. are examples of feelings, which are considered as negative in a TC setting, when they are used for resisting personal change. Showing certain negative attitudes (built on these emotions) can masque real emotions and impede a personal introspection and development, whereas positive attitudes implicate a readiness to change, honesty, belonging, etc.

Although the basic principles of the 'old' encounter remain the same (De Leon, 2000), an important evolution has taken place. During the years the encounter groups became less intensive (extreme) and more sensitive, evolving from harsh indictment into an intense form of dialogue.
Moreover, the old encounter groups were characterized by confrontation, during which the attention was primarily aimed at the person who was confronted. 'Towards-messages' (i.e. expressions from the one confronting towards the one who was confronted) prevailed. In the new encounter, much more attention is given to the person who started the confrontation, indicating the growing importance of considering 'back-messages' (i.e. expressions from the confronted person towards the one who is confronting) (Bracke, 1996).
Poulopoulos (1995, p. 103) made the following observation: 'The way of dealing with the client and a respect for human rights comprises the greatest challenge for every therapeutic system. Increasingly new techniques are coming to the surface that include that of positive support and limit the negative confrontation'. Bracke (1996, p. 73), an addiction therapist in the TC 'De Kiem' (Belgium) since 1977, adds: 'The encounter and it's hard confrontations strove to 'break' the image of the addict. However it often happened that this radical method did not destroy the 'image' but that the person himself felt broken, devalued, humiliated and without support. Consequently, many stopped their treatment prematurely because they did not get time to experience the support and comprehension that made the therapy tolerable'.

These clinical observations reflect current scientific findings on early client drop-out in therapeutic communities. Several authors (Holland, 1986; Marlatt, 1985) warn us not to provide too intense treatment during the first period of admission in a TC. To improve client retention, also Goldapple and Montgomery (1993) recommend demonstrating 'understanding, empathy and tolerance toward new admissions' early trial-and-error learning behaviors, different rates of learning, and behavioral responses to depression, anxiety and distress'. In this context, Van der Meer (1997, p. 37) speaks of 'the necessity to avoid destructive confrontation'.

It is the aim of this chapter to investigate whether the emergence of a new encounter culture in drug-free (prison-based) therapeutic communities can be empirically underpinned: 'new' encounter groups should change from harsh confrontation to dialogue and discussion. Hypotheses, deducted by means of a standardized protocol (see table 3.1.), are put forward.

It is assumed that comparing the material of the 'old' and 'new' forms of encounter will confirm that:

1. There will be a more equal 'dialogue' between participants in the new encounter, in the form of a more balanced equilibrium between 'towards' and 'back'-messages, whereas the old encounter will reveal a preponderance of 'back'-messages.
2. In the new encounter the participants (both residents and staff members) will discuss more and be more supportive in their behavior. Behavior is more confrontational in the older form of encounter.
3. In the new encounter (as compared to the old one) more positive feelings will be noticed.
4. In the new encounter more positive attitudes than in the old one will be observed.
5. When the above-mentioned hypotheses are focused on sub-groups of people taking part in the encounter (staff members, 'older' and 'newer' residents), differences between 'older' and 'newer' participants will be noticed.

Table 3.1.: Categories and subcategories of coding protocol

Code	Function	Direction	Behavior	Emotion	Attitude
1	Staff	Toward	Confrontational	Positive	Positive
2	Old resident	Back	Supportive	Negative	Negative
3	New resident				

3.2. METHOD

Due to the 'historical' context (i.e. the lack of availability concerning congruent text material of past encounters) the research was based on a N=1 comparative case study. The literally transcribed text material of an old encounter which took place at the drug-free TC 'De Kiem' (Belgium) in 1980 (Broekaert,

1980) was compared to that of a recent encounter (Broekaert, Bogaert et al., 2000). Both encounter groups took place under similar circumstances in the same community and were led by the same therapist.
In 1980, during a period of one month, all eight ongoing encounter groups (each of which lasted approximately 90 minutes) were tape-recorded. The proceedings of one encounter group – selected at random – were literally transcribed (Broekaert, 1980). In 2000, the same procedure was repeated (Broekaert, Brouckaert et al., 1999; Broekaert, Bogaert et al., 2000). Obviously, all the other group members were different.

Six master-level students in Educational Sciences (Broekaert, Bogaert et al., 2000), analyzed the material to its basic elements ('hermeneutic units'), and coded and classified the elements according to the standardized protocol, as outlined in table 3.1. They made use of the statistical software package WinMAX97 (Kuckartz, 1997), which facilitates the code-and-retrieve process.

These fifth-year students received a comprehensive training in quantitative as well as qualitative research methods, including the methodological background and usage of qualitative software packages (such as WinMAX). Moreover, they have been working as trainee staff members for one month in the therapeutic community 'De Kiem' (in which the encounter groups took place). During this period, they actively participated in the daily life of the TC, which is structured according to a detailed time-schedule and work planning. Next to taking part in these activities, they also were present as observers during several therapeutic groups, such as encounter groups, emotional groups, etc. The students' presence in the TC created an atmosphere of trust and acceptance between residents and students, which facilitated the data collection.

After this one-month period of participant observation, the students first transcribed the tape-recorded proceedings of the encounter groups and analyzed the transcripts by means of the text analysis software package WinMAX97. They compared and discussed the results together and consequently refined and attuned the definitions of categories and subcategories that constituted the hypotheses (see table 3.1.).

This way, a common tree-structure developed out of the raw material. Later, in two separate groups of three people, they re-coded the material, after which a new comparison and discussion of the results took place. The coded segments of these two groups were systematically reviewed and compared and proved to be the same for 97.7% of the cases in the old encounter and for 97.8% in the new encounter.

A 'towards' direction in the communication sequence consists of everything that one person (or those supportive him) tell or ask the person being confronted. Every reaction to this forward confrontation is considered a back direction.

Behavior can be attacking, frustrating, disdaining, protesting, … (confrontational) (e.g. 'I feel like you have betrayed me') or encouraging supportive, opening up, sustaining, … (supportive) (e.g. 'Please continue to express your feelings').

Emotions can be aggressive, angry, sad, bitter, … (negative) (e.g. 'I am sick and tired of it') or happy, caring, friendly, released, … (positive) (e.g. 'I really feel relieved now').

Attitudes can be in accordance with the value system of the TC: open, honest, constructive, understanding, … (positive) or in discordance: closed, obstructive, dishonest, rejecting, … (negative).

Participants are coded as staff, older or newer residents. Older residents are defined as those clients who have spent already some time (generally 2 – 4 months) in the program successfully and who are formally recognized by their peers and staff members as role models in the TC. They are the carriers of the TC-culture and have the most important responsibilities at client-level in the community.

Newer residents (cf. 'phase 1' in De Leon, 2000, p. 200) identify themselves as community members; increase participation in groups and accept the seriousness of drug use and other problems, showing some separation from sub-culture, street language, etc. Older residents (cf. 'phase 2 & 3' in De Leon, 2000, p. 200) set an example for other residents, accept full responsibility for behavior problems and solutions, acquire group skills and are accepted to act as facilitators in the encounter group. They run the house as coordinator and assist the staff in monitoring the facility (De Leon, 2000, p. 200). Staff members have primary responsibility for the operation of the facility, the clinical status of the residents as well as supervising and conducting the groups (De Leon, 2000, p. 121).

3.3. RESULTS

The exact numbers of coded communication sequences drawn from both the old and the new encounter were systematically compared, taking the four main

variables into account: direction (n=1,525), nature of behavior (n=1,441), sort of emotion (n=1,444) and kind of attitude (n=1,441) which accompanied the communicated expression. The observed differences in exact numbers of communication units can be explained by the decision to exclude all expressions categorized as 'not situated' or 'neutral' on the relevant variable.

A three-way frequency analysis 'communication characteristic by encounter group by participant category' was performed to develop a hierarchical log-linear model for each communication characteristic.

3.3.1. RESULTS FOR THE COMMUNICATION CHARACTERISTICS (FIRST-ORDER EFFECTS)

Partial chi-square tests for first-order effects were statistically significant (p=.000) for all communication characteristics (direction, behavior, emotion and attitude) (see table 3.4.). Considering the communication units in both encounters (see table 3.2.) generally,

- more towards (79.5%) than back messages (20.5%) can be observed;
- more supportive (82%) than confronting (18%) behavior can be identified;
- the ventilated emotions are more positive (61%) than negative (39%);
- the associated attitudes are more positive (93%) than negative (7%).

Table 3.2.: Cross-tabulation communication characteristics: old and new encounters

	Total *n*, Frequency (%)	**Old encounter, Frequency (%)**	**New encounter, Frequency (%)**
Direction			
Towards	1,213 (79.5)	657 (86)	556 (73)
Back	312 (20.5)	107 (14)	205 (27)
Behavior			
Confrontational	264 (18)	194 (26)	70 (10)
Supportive	1,177 (82)	551 (74)	626 (90)
Emotion			
Positive	877 (61)	478 (64)	399 (57)
Negative	567 (39)	268 (36)	299 (43)
Attitude			
Positive	1,342 (93)	679 (91)	663 (95.5)
Negative	99 (7)	68 (9)	31 (4.5)

3.3.2. RESULTS FOR THE COMMUNICATION CHARACTERISTICS IN THE OLD AND NEW ENCOUNTER

All partial chi-square tests for two-way interactions with encounter group were significant for direction (p=.000), behavior (p=.000), emotion (p=.012) and attitude (p=.001) (see table 3.4.)

- DIRECTION

In the new encounter, the relation between 'towards and back'-messages is more balanced than in the old encounter. More in detail, a decrease in towards messages from 86% in the old encounter to 73% in the new encounter can be observed (see table 3.2.).

- BEHAVIOR

A decrease in confronting actions from 26% in the old encounter to 10% in the new encounter can be identified (see table 3.2.).

- EMOTION

A decrease in positive emotions from 64% in the old encounter to 57% in the new encounter can be observed (see table 3.2.).

- ATTITUDE

An increase in positive attitudes from 91% in the old encounter to 95.5% in the new encounter can be identified (see table 3.2.).

3.3.3. RESULTS PRO SUBCATEGORY (STAFF MEMBERS, OLDER AND NEWER RESIDENTS)

The exact numbers of communication sequences were also compared on the four main variables, itemized for three specific subcategories of participants (staff members, older and newer residents). Again, communication units (per variable) categorized as 'not situated' or 'neutral' were excluded from the analysis.

All partial chi-square tests for two-way interactions with participant category were significant for direction (p=.000), behavior (p=.000), emotion (p=.000) and attitude (p=.000) (see table 3.4.).

- DIRECTION

Almost all communication units of staff members were coded as towards messages (near 100%); a tendency, which could also be observed for the older residents (70%). The general tendency towards a balanced equilibrium between 'towards and back'-messages could only be observed for the newer residents (towards (57%) and back (43%) messages) (see table 3.3.).

- BEHAVIOR

When focusing in greater detail on communication sequences of the different participants of the encounter, the general trend of the majority of associated behavior as being supportive could be identified for staff members, older and newer residents. Almost all (96.5%) associated behavior of staff members was coded as 'supportive', followed by the newer residents with 80.5% of supportive behavior and finally the older residents with 67% of supportive behavior (see table 3.3.).

- EMOTION

The general conclusion of less positive and more negative emotions, ventilated through the communication sequences in the new encounter can be identified for the staff members (76.5% of the expressed emotions were negative). Older (85%) as newer (91%) residents both expressed a majority of positive expressions (see table 3.3.).

- ATTITUDE

Focusing on the attitudes of the different participants within the old and new encounter, the associated attitudes are mostly positive. Almost all (near 100%) of the attitudes associated with the communication units of staff members were positive. The older residents (94.5%) also showed an overwhelming majority of positive attitudes. The same tendency could be observed for the newer residents; they expressed 75% positive attitudes versus 25% negative attitudes (see table 3.3.).

Table 3.3.: Cross-tabulation communication characteristics/participant category: old and new encounters

	Total *n* Old and new encounters, Frequency (%)	**Old encounter, Frequency (%)**	**New eEncounter, Frequency (%)**
Staff direction			
Towards	612 (100)	303 (100)	309 (99)
Back	2 (0)	0 (0)	2 (1)
Older resident direction			
Towards	437 (70)	312 (100)	125 (41)
Back	186 (30)	3 (0)	183 (59)
Newer resident direction			
Towards	164 (57)	42 (29)	122 (86)
Back	124 (43)	104 (71)	20 (14)
Staff behavior			
Confrontational	21 (3.5)	15 (5)	6 (2)
Supportive	575 (96.5)	282 (95)	293 (98)
Older resident behavior			
Confrontational	191 (33)	149 (49)	42 (15)
Supportive	387 (67)	157 (51)	230 (85)
Newer resident behavior			
Confrontational	52 (19.5)	30 (21)	22 (18)
Supportive	215 (80.5)	112 (79)	103 (82)
Staff emotion			
Positive	140 (23.5)	85 (29)	55 (18)
Negative	456 (76.5)	212 (71)	244 (82)
Older resident emotion			
Positive	494 (85)	265 (86)	229 (84)
Negative	87 (15)	42 (14)	45 (16)
Newer resident emotion			
Positive	243 (91)	128 (90)	115 (92)
Negative	24 (9)	14 (10)	10 (8)
Staff attitude			
Confrontational	592 (100)	296 (100)	296 (100)
Supportive	1 (0)	1 (0)	0 (0)
Older resident attitude			
Positive	550 (94.5)	307 (100)	243 (89)
Negative	32 (5.5)	1 (0)	31 (11)
Newer resident attitude			
Positive	200 (75)	76 (53.5)	124 (100)
Negative	66 (25)	66 (46.5)	0 (0)

3.3.4. RESULTS PRO SUBCATEGORY (OLDER AND NEWER RESIDENTS) IN THE OLD AND THE NEW ENCOUNTER

The partial chi-square tests for three-way interactions with participant category and encounter group were significant for direction (p=.000), behavior (p=.000) and attitude (p=.000). Only the partial chi-square tests for three-way interactions for emotion was not significant (p=.176) (see table 3.4.)

- DIRECTION

Partial cross-tabs tables of subcategory of participant with associated direction for the old en new encounter show that in the old encounter almost 100% of the older residents' and 29% of the newer residents' statements express a towards message when communicating within the encounter group. When focusing on the new encounter, 41% of the older residents' and 86% of the newer residents' statements express towards messages. This indicates a decrease in towards messages for the older residents in the new encounter, together with an increase in back messages. When looking at the newer residents however, an increase in communication sequences towards as well as a comparable decrease in back-messages should be noted (see table 3.3.)

- BEHAVIOR

When focusing on communication sequences of the different participants of the encounter, the general trend of increased supportive behavior and the consequent decrease of confrontational behavior are especially true for the older residents. Partial cross-tabs tables of participant category with behavior for the old en new encounter reveal that in the old encounter 51% of the older residents' and 79% of the newer residents' statements express supportive communication, whereas in the new encounter 85% of the older residents' and 82% of the newer residents' statements show supportive behavior (see table 3.3.).

- ATTITUDE

Partial cross-tabs tables of participant category with associated attitude for the old en new encounter show that in the old encounter 100% of the older residents' and 53.5% of the newer residents' statements express positive attitudes, whereas in the new encounter 89% of the older residents' and 100% of the newer residents' statements indicate positive attitudes. This indicates that more negative attitudes can be identified for the older residents in the new encounter, as compared to within the old one. Newer residents show more positive attitudes in the new encounter as compared to within the old encounter (see table 3.3.).

Table 3.4.: Partial χ^2 tests (hierarchical log-linear analysis)

	Partial χ^2	**P**
Direction	568.663	.000**
Behavior	625.183	.000**
Emotion	67.072	.000**
Attitude	1276.375	.000**
Direction X encounter	51.720	.000**
Behavior X encounter	65.612	.000**
Emotion X encounter	6.378	.012**
Attitude X encounter	11.980	.001**
Direction X participant	377.274	.000**
Behavior X participant	195.827	.000**
Emotion X participant	632.012	.000**
Attitude X participant	160.163	.000**
Direction X participant X encounter	326.314	.000**
Behavior X participant X encounter	15.498	.000**
Emotion X participant X encounter	3.480	.176**
Attitude X participant X encounter	114.309	.000**

Note: * *p<.05*
** *p<.01*

3.4. DISCUSSION

Summarizing the main findings of the present research, the following results are most obvious. In the new encounter, the relation between 'towards and back'-messages is more balanced than in the old encounter. Associated behavior in the new encounter is found to be more supportive, whereas ventilated emotions are more negative than in the old encounter. The numbers of communication units within the old and new encounter, characterizing a positive or negative attitude, seem to have remained stable over the years. When focusing on subgroups of participants (older and newer residents and staff members), it is not always possible to identify the main results for all three groups.

When comparing both encounters, it is worth noting that although the back-messages increase in the new encounter, the towards-messages still constitute the largest number of analyzed communication units. This can probably be explained by the fact that direct confrontation remains (and should remain) the prominent tool within the encounter group (Broekaert, 2001; De Leon, 2000; Sugarman, 1974). Consequently supportive behavior is essentially associated with

confrontation. This was true in the past and is perhaps even more true now. An increase in dialogue, however, should not be at the expense of the intensity, sharpness and directness of the communicated message. Giving more attention to the person confronting promotes true introspection. It leads to greater depth, enhances the significance of the message and prevents counterproductive acting out. More meaningful and less aggressive confrontations also decrease male chauvinism and macho-like behavior during the encounter groups. In both the old and new encounter the staff members predominantly provide support and this fact confirms their position as 'facilitators' rather than as 'directors' of the group process. They are the guarantors of security and trust. It is interesting to notice that in the new encounter the older residents who are the primary role models in the TC confirm in their interventions the move towards support. Instead of taking over and continuing the confrontation, they rather try to build up a dialogue with their 'partners'. The newer residents at the other hand get more time to learn how to act during an encounter.

The staff members often use irony and provocation while facilitating the encounter process. It is unclear to what level this is suitable. In the past, 'over-acting' could also be observed, e.g. ventilated through exaggerated hugging and embracing at the end of the session. It seems clear that 'negative feelings' should not be pushed away but 'lived' through. The fact that we experience now (as well as in the past) a stabilization of positive attitudes proves that - in general - the TC is enthusiastically devoted to its project. Even if techniques and approaches are in a constant state of evolution, the dedication of staff members remains essential. Belief in the concept increases its chances of success. But how to explain the tendency towards a less positive attitude as displayed by older residents in the new encounter? Older residents become more critical towards the program and start to question the concept and philosophy behind it. They feel safe in the community in general and act freely within the encounter group. They have discovered a space in which they can be themselves. This is actually a big step forward in the healing process of a formerly addicted person. However, newer residents could regard criticism as a negative attitude, due to difficulties of interpretation.

Whilst discussing the conclusions in greater depth, intriguing questions emerge concerning possible changes in the target population over the years. Undoubtedly, the treatment systems have further developed, going together with a more advanced selection of the target population towards adapted approaches. The implementation of diagnostic and motivational instruments in therapeutic communities could pre-select individuals who are more open to communication and dialogue. Moreover, a general tendency can be observed (certainly in Europe)

towards a more open disclosure and discussion of personal problems. The demystification of drug problems might also be a factor.

The position of the therapist remains a very pertinent issue. It is probably an exceptional situation that the same therapist continued to lead the sessions for a period of twenty years. It is likely that his skill developed over that period of time. It probably requires a lot of experience to implement the more dialogue-like encounter in the TC. One must not forget that 'professionals' took over a lot of knowledge of the early-TC ex-addicts, which undoubtedly influenced the introduction of their 'own' therapeutic approaches.

Although generalization of the findings presented in this paper is impossible because of the limited client-level data (obtained in one TC), the results are in accordance with the current literature and clinical observations in the field of therapeutic community practice (Bracke, 1996; Poulopoulos, 1995; Van der Meer, 1997). Undoubtedly, further research has to be undertaken to reach a deeper understanding of the evolution in encounter group methods, which is imbedded in the maturation of the TC movement in general.

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4

The Assessment of Intellectual Disabilities in Drug-Involved Criminal Offenders:

A pilot study in Belgian correctional establishments [3]

Seventy-nine incarcerated drug-involved criminal offenders completed the Raven Standard Progressive Matrices. Almost half of the participants scored definitely below average and 15% of the total group could be labeled as 'intellectual impaired', based on norms published in the Raven SPM manual (pc ≤ 5). In order to investigate other domains set forth in the 2002 AAMR definition on intellectual disability (ID), corresponding items from the European version of the Addiction Severity Index were selected. This was possible because concepts of ID and substance abuse are characterized by a comparable evolution from a disorder-oriented point of view towards an ecological person-oriented approach. The results indicate the importance of taking context-oriented variables into account when assessing ID.

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4.1. THEORETICAL BACKGROUND

There is growing scientific and clinical attention for issues related to the assessment and treatment of substance abuse problems in the special target group of criminal offenders with intellectual disabilities (ID) (McGillivray & Moore, 2001; Mendel & Hipkins, 2002). Some studies already demonstrated existing interrelations between intellectual abilities on the one hand and motivation to change drug-related behavior and readiness to start substance abuse treatment on the other hand (Blume, Davis, & Schmaling, 1999; Fals-Stewart & Schafer, 1992). In this respect, a study targeting dually diagnosed clients, for instance, showed that persons with special intellectual needs seemed to be less motivated to change, as compared to their counterparts without these specific needs (Blume et al., 1999). As motivation and readiness - on their turn - have been identified as reliable predictors of treatment success, this could have far-reaching consequences (DiClemente, 1999).

However, it is not always obvious to identifying the clients with special intellectual needs. The assessment of the diagnostic criteria, related to the definition and classification of intellectual disability is not self-evident and therefore demands specific attention (AAMR, 2002; Holland, Clare, & Mukhopadhyay, 2002; McBrien, 2003).

4.1.1. CLASSIFICATION OF PERSONS WITH ID

Current systems to define and/or to classify persons with intellectual disabilities have been undergoing an important evolution. The *International Classification of Functioning, Disability and Health (ICF)* (WHO, 2001), a complementary instrument to the *International Classification of Diseases and Related Health Problems (ICD-10)* (WHO, 1993) makes a distinction between the concept of (non-problematic) functioning and the term disability, which is used to denote problems in functioning. Three levels further constitute human functioning: body functions, activity and participation. Both disabilities as well as functioning are – on their turn – influenced by health conditions and contextual (environmental and personal) factors (AAMR, 2002). Instead of exclusively attributing a disability to the most obvious impairment – often situated within the person (i.e. significant limitations in body functions, such as intellectual functioning) – major attention is given to the complex interrelations between physiological, psychological, social and societal components (Arthanat, Nochajski, & Stone, 2004; Ueda & Okawa, 2003).

According to the 10th edition of *Mental Retardation: Definition, Classification and Systems of Supports* of the American Association on Mental Retardation (AAMR), the leading association with regard to the definition and classification of intellectual disabilities, mental retardation is defined as a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social and practical adaptive skills, originating before the age of 18 (AAMR, 2002). Consequently, the AAMR (2002) definition is multi-dimensional and assesses strengths and weaknesses on five domains: intellectual abilities; adaptive behavior; participation, interaction and social roles; health and context. It aims at categorizing people with intellectual disabilities on basis of their support needs, rather than on their cognitive abilities solely, as it used to be (Buntinx, 2003).

The current version of another major classification system, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (APA, 1994), further expands the classification of mental disorders coded in the ICD-10 and is generally congruent with the AAMR-model (AAMR , 2002).

The ICF classification system, focusing on disability in general, and the AAMR system, specifically tackling mental retardation, have important basic principles in common. Both models are built upon bio-psycho-social insights, targeting the person as a whole from an ecological point of view. Moreover, the adaptive skill areas set forth in the AAMR system are highly congruent with the activities and participation levels in the ICF model (AAMR, 2002). In this chapter, we chose to use the AAMR system. First of all because it explicitly focuses on intellectual disabilities; secondly, the model also incorporates subjective dimensions of functioning (AAMR, 2002; Ueda & Okawa, 2003).

4.1.2. ASSESSMENT OF INTELLECTUAL FUNCTIONING & ADAPTIVE BEHAVIOR

Assessing the five AAMR-domains, especially focusing on intellectual functioning and adaptive behavior as most critical components of the classification system, is complex. Therefore, it is not always clear, nor self-evident, which assessment instruments or protocols should be used.

Intellectual abilities, still regarded at as most important criterion, are – up until now – best represented by IQ-scores, although this only covers a limited section of (conceptual) intelligence (AAMR, 2002). Several authors have developed

theories and definitions regarding intelligence, illustrating the complex nature of this concept. Gardner (1993) identifies multiple facets within intellectual abilities, rather than defining intelligence as one uniform concept. Greenspan (see for instance Greenspan & Benderly, 1998) has developed an influencing theory stressing the strong interrelation between intelligence and emotions. Within this respect, the use of standardized tests such as the Wechsler Adult Intelligence Scale or the Raven Standard Progressive Matrices, can only be considered as part of a more comprehensive assessment for labelling, categorizing and supporting someone as having an intellectual disability, depending on the main purpose of the assessment process.

Adaptive behavior is described by the AAMR (2002, p. 73) as 'the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives'. These competencies are broad and diverse and they relate to a large spectrum of life domains, such as communication, health, social skills, work and employment, self-direction, etc. Therefore, the assessment of adaptive behavior should incorporate an array of different everyday skill areas, which is not self-evident in secure settings, including prisons or large institutions. A recent study by Bielecki and Swender (2004), focusing on the assessment of social skills in people with intellectual disabilities concluded that social skills assessment, and by extension other adaptive competencies, should be embedded in an overall assessment package. By doing so, important relations between the different areas of adaptive behavior could be investigated. As the development of a suchlike assessment protocol is already difficult for people with disabilities in the mainstream, specific problems arise when focusing on incarcerated criminal offenders with ID.

The most important reason goes back to the utility of existing instruments for the special target group of incarcerated criminal offenders. There are many adaptive behavior measures, of which the Vineland Adaptive Behavior Scales (VABS) are probably the most frequently used, because the design of the instrument fully corresponds with the criteria set forth in the AAMR-2002 definition on mental retardation (Beail, 2003). However, even the VABS have recently been criticized, primarily because of psychometric difficulties in general and outdated (American) norms more in particular (Beail, 2003). Moreover, the most current adaptive behavior measures, including the VABS, rely on information obtained from a third party, close to the individual being assessed (AAMR, 2002; Bielecki & Swender, 2004). Usually, these respondents are relatives, teachers or treatment staff, who are very familiar with the client. As many detainees are isolated while

imprisoned, often leading to feelings of loneliness (Rokach, 2001), the availability of legitimate informants is often not guaranteed. Other reasons, which hamper the assessment of ID in general and adaptive behavior more in particular within secure settings, such as prisons, include practical difficulties (lack of time and resources); the 'security versus treatment dilemma' in correctional establishments and problems related to 'measure' and assess strengths and weaknesses when institutionalized.

4.1.3. SIMILARITIES BETWEEN HEALTH AND CARE PARADIGMS

Both the field of disability research and substance abuse (treatment) research are characterized by a comparable evolution from a disorder-oriented point of view towards a more ecological person-oriented approach. Recent theoretical insights, stressing the interrelationship of the sociological, economical, historical, cultural and political context (AAMR, 2002; Klaue, 1999), lead to comparable contemporary definitions, classifications and instruments/tests both within the field of substance abuse (such as the Addiction Severity Index – ASI, McLellan, Luborsky, O'Brien, & Woody, 1980) as within the field of disability research (AAMR, 2002; Van Loon & Van Hove, 2002).

The focus is no longer solely pointed towards 'deviances' or 'diseases' ('*old* thinking'), but is expanded to the whole person, with special attention for the 'context' in a broad sense ('*new* thinking'). New assessment instruments are used in order to broaden the scope, for instance by not exclusively relying on IQ-scores when identifying people with intellectual disabilities, but expanding the view by incorporating other dimensions, such as adaptive behavior and social competencies; or by not exclusively relying on medical (DSM) definitions and classifications with regard to addiction (APA, 1994), but concentrating on the severity of problems in different life domains of the substance abuser.

4.1.4. GOALS OF THE STUDY

Although these new paradigms and definitions are considered quintessential nowadays, remainders of 'old' thinking are still influential, for instance in correctional establishments, where the concept of ID is still often narrowed to IQ-figures and performance on intelligence tests, without taking other dimensions identified by the 2002 AAMR definition or the ICF-classification into account.

Therefore, this chapter explores a course to link 'old' and 'new' thinking in the field, by combining research findings and standardized instruments from both disciplines (disability research and substance abuse (treatment) studies). Data related to intellectual functioning, measured by the Raven Standard Progressive Matrices, are expanded with important context-oriented variables, primarily related to the adaptive behavior skills, mentioned in the AAMR 2002 definition.

In order to do this, corresponding items from the seven life domains of the EuropASI (physical health; education and work; alcohol use; substance use, legal status; family and social relationships and psychological status) are compared with the five domains set forth in the AAMR (2002) definition on mental retardation (cognitive abilities; adaptive behavior; participation, interaction and social roles; health and context). By doing so, the paper aims at investigating to what degree current scientific health and care paradigms could be combined in order to assess intellectual disabilities in drug-involved criminal offenders. Moreover, the chapter looks into differences between persons labeled as having ID and their counterparts without ID from a multi-dimensional perspective, focusing on the assessment domains recited in the AAMR (2002) definition.

4.2. TERMINOLOGY

The fact whether or not and on basis of which criteria people are (correctly) labeled as having an intellectual disability can yield extremely important consequences. This seems especially true for people with mild intellectual disabilities (Blume, Davis, & Schmaling, 1999; McBrien, 2003; Simpson & Hogg, 2001). As people with mild ID are generally living independently in the community nowadays, under influence of recent care paradigms, such as normalization, integration and inclusion, they are more susceptible for harm, including alcohol and drug use (McGillicuddy & Blane, 1999; Lottman, 1993). This group includes persons who can be situated in the borderline zone between 'normally achieving' and 'having an intellectual disability'. They form the 'forgotten generation', sometimes not recognized as having ID (Tymchuk, Lakin, & Luckasson, 2000).

In order not to neglect the needs of this subgroup, there has been chosen to define 'intellectual disability' in this chapter as those clients who score at or below the fifth percentile on the Raven Standard Progressive Matrices (SPM). And by further broaden our assessment perspective with EuropASI items, corresponding

with the AAMR domains, we include life- and substance abuse related difficulties for those persons whose problems are not considered always from a multi-dimensional perspective.

4.3. METHOD

4.3.1. DATA COLLECTION

The data used in this chapter were collected during November 2001 and December 2002 as part of a larger study focusing on characteristics (primarily intellectual functioning and motivation & readiness towards treatment) of drug-involved criminal offenders. All the participants were incarcerated in the correctional establishments of Brugge, Gent, Leuven or Merksplas (Flanders, Belgium), which have a communal capacity of almost 1900 prisoners. Criminal offenders were eligible for the study if they met two main criteria: showing a history of problems associated with substance use, as shown in the conviction(s) (i.e. drug-related offences) and/or personal files within the PSD (psychosocial)-section of each prison and displaying an appropriate knowledge of the Dutch language, in order to make a regular conversation possible. PSD-staff members identified the eligible participants on basis of these indicators, after which lists containing names of these offenders were made available to the researchers. The latter selected the participants at random, initiated the first contact with the clients and asked for their cooperation in the research project. In one prison (Merksplas), this was done by one of the prison staff members (not belonging to the PSD). In all cases, necessary informed consent was obtained by the researchers.

The data collection consisted of individual and personal face-to-face interviews (by means of EuropASI, Raven and CMRS), carried out by the first author and two master-level students in Educational Sciences (Ghent University). The data collectors received training in administering the EuropASI and executed the first interviews two-by-two in order to maximize consistency when gathering the data. The interviews usually lasted between 1 hour and 3-5 hours, when possible finished in one session (with regular breaks if necessary), but often spread over two or three consecutive moments. If necessary, special attention was given to make the questions well understood, for instance by repeating questions, summarizing the participant's answer or returning to questions if answers were contradicting previously obtained information.

4.3.2. SAMPLE

Given the delicate nature of the research project, only 94 persons were willing to cooperate in the research project. Of these 94 people, only 79 fully participated in the study. The remaining persons left before all the instruments could be administered. Although difficult to determine how many persons refused to take part in the study (due to the fact that some persons were released or transferred just before or during the research period), figures indicate a refusal rate of about 40% (De Pauw & Serlet, 2003).

The majority of the participants were male (97.5%), with an average age of 31 years (SD: 6.52), ranging from 20 to 50. The majority of the solicited persons have the Belgian nationality (84.8%), although several of the participant's parents were not born in Belgium (24.4% of the fathers and 20.5% of the mothers), indicating that a substantial proportion of the sample has another ethnic-cultural background.

The most problematic drug used during lifetime is identified by the participants as heroin (36.7%), cocaine (20.3%) amphetamines (8.9%), cannabis (6.3%) and alcohol (5.1%). The average length of in-prison illegal drug use during the month prior to the interview varied from 13.92 days (SD: 13.14) for cannabis, 8.09 days (SD: 12.42) for over-the-counter medicines and 2.66 days (SD: 8.58) for other substances to 0.89 days (SD: 2.68) for heroin. The length of the served prison sentence varied from 7 to over 96 months, with a mean of 62.84 (SD: 29.34). The average number of arrests varied from 5.42 (SD: 7.46) for crimes against property, 4.66 (SD: 12.74) for possession and dealing and 3.55 (SD: 7.74) for crimes of violence. These arrests resulted in an average of 7.93 (SD: 8.96) convictions.

4.3.3. INSTRUMENTS

The *Raven Standard Progressive Matrices* (Raven, 1958) is a non-verbal test to assess the general ability to reason, and it 'can provide a valid means of assessing a person's present capacity for clear thinking and accurate intellectual work' (Raven, Court, & Raven, 1988, p. 22). It is important to stress that the test was designed to measure 'g' (general ability) (Raven, 2000), regardless of verbal capacities or academic achievement (O'Leary, Rusch, & Guastello, 1991). Moreover, the Raven SPM has some distinctive positive features, especially with regard to the present study: the test is culture-unbiased, not timed, suitable for men and women and valid and reliable, as shown for instance by the high correlations with the

Wechsler intelligence tests (O'Leary et al., 1991; Raven, 2000), which are considered as the most reliable estimates, when individually administered (McBrien, 2003).

The *EuropASI* is the European version of the Addiction Severity Index (McLellan et al., 1980), a multidimensional clinical and research instrument (Brochu, Guyon, & Desjardins, 1999). It is administered as a semi-structured interview focusing on seven areas (connected to alcohol and substance use): physical health; education and work; alcohol use; substance use, legal status; family and social relationships; and psychological status. It is one of the most widely used instruments within the addiction field, resulting in severity ratings by the interviewer on these seven areas (based on factual information and subjective perceptions of the client). The severity ratings vary from 0 (no treatment needed) to 9 (treatment definitely necessary in life-threatening situation) (Kokkevi et al., 1993). The reliability and validity has been subject to several studies, which have underpinned its usefulness for several populations (including prisoners, drug court clients, substance abusers with severe psychiatric problems, etc.) and within different treatment settings (Carise et al., 2001).

4.3.4. DATA ANALYSIS

Although far from being perfect, the AAMR (2002) model describes the use of standardized intelligence measures to classify persons with and without ID as the most optimal method up until now. Therefore, the Raven SPM scores served as the primary criterion to assign the participants to one of the research groups (people with and without ID), in analogy with daily practice in (Belgian) correctional establishments, where IQ-scores are commonly used. In order to interpret the raw scores, we used available Belgian norms and cut-off (5th percentile) scores, published in the official manual of the test (Ed. 1998).

As mentioned already in the introduction, relevant variables from the EuropASI domains (physical health; education and work; alcohol use; substance use, legal status; family and social relationships and psychological status) were itemized for the five domains set forth in the AAMR (2002) definition on mental retardation: cognitive abilities; adaptive behavior; participation, interaction and social roles; health and context. By doing so, the potential interrelationship of 'new' health and care paradigms in substance abuse treatment research and disability research is underscored. Frequency tables, cross tabulations and chi-square tests (Yates

correction for continuity was applied where indicated) were used to analyze the data.

4.4. RESULTS

4.4.1. COGNITIVE ABILITIES

Based on the results of the Raven Standard Progressive Matrices, 49.4% of the participants score 'definitively below average' when it comes to intellectual functioning. Moreover, 15.2% of the total group can be labeled as 'intellectually impaired' (i.e. score below or at the 5th percentile) (cf. table 4.1.) based on the manual of Raven's SPM. One participant, who scored just above the 5th percentile, is included in this category in order to account for the standard error of measurement (SEM) (cf. AAMR, 2002). When the school results and educational levels are considered, the majority (62.8%) of the participants finished only primary school successfully. The remaining participants obtained a degree in technical and vocational training (16-18 years) (19.2%), technical secondary school (6.4%), special primary or secondary education (3.9%), higher education (3.9%), general secondary school (1.3%) or do not have a degree (2.6%).

Table 4.1.: Scores Raven RPM

	n	**%**
Intellectually superior (pc ≥ 95)	2	2.5
Definitively above average (pc ≥ 75)	8	10.1
Average (25 < pc < 75)	30	38.0
Definitively below average (pc ≤ 25)	27	34.2
Intellectually impaired (pc ≤ 5)	12	15.2
TOTAL	**79**	**100.0**

4.4.2. OTHER AAMR DIMENSIONS

Relevant items from the EuropASI were selected in order to clarify the other domains used in the AAMR (2002) definition on mental retardation. Next to a general overview, differences between people who can be labeled as 'intellectually impaired' and the other participants are presented.

- HEALTH

When focusing on physical health-related problems, over a third of the participants suffer from chronic physical complaints, almost a third has hepatitis and almost half received some sort of medical treatment in the last 30 days (whilst incarcerated). A small minority reported to suffer from HIV, whilst more than 10% of the clients received an allowance for medical reasons. No significant differences could be found between people with and without ID.

Psychological problems seem to be quite common: more that 60% of the participants suffered from depression, anxiety or difficulties to control aggression ever in life. A third of the clients reported to have attempted suicide. Other problems include difficulties to understand, reason and remember (37.3%) and hallucinations (18.4%). Forty percent of the participants received prescribed medicines once in their life, and/or were treated in residential facilities (25%) or outpatient services (13.1%). People labeled as 'intellectually impaired' more frequently reported to have had hallucinations once in their lifetime and suicide thoughts during the last 30 days. An overview of health-related issues is presented in table 4.2.

- ADAPTIVE BEHAVIOR

In general, a small proportion of the participants experienced difficulties understanding questions, whilst the participants labeled as 'intellectually impaired' showed significant higher rates in this respect (45.5%). The majority of the interviewees committed crimes against property, crimes of violence and crimes connected with possession and dealing of drugs; no differences between participants with and without the label 'intellectually impaired' were found. When focusing on the (financial) resources, over 60% indicated to obtain money from work, whilst almost 60% received money from family members. It is noteworthy to stress that people labeled as 'intellectually impaired' less frequently earned money from work. For an overview of adaptive behavior, see table 4.3.

Table 4.2.: Percentages and distribution of EuropASI variables, itemized for the AAMR (2002) dimension 'health'

	Total (%) (n=79)	**Raven score pc ≤ 5 (%)** (n=12)	**Raven score pc > 5 (%)** (n=67)	**χ^2**	**Sign.**
Physical					
Chronic physical complaints	32.9	33.3	32.8	.001	n.s.
Hepatitis	29.1	25.0	29.9	.752	n.s.
HIV	2.5	0.0	3.0	1.895	n.s.
Prescribed medicines on regular basis	31.6	41.7	29.9	.657	n.s.
Allowance for medical reasons	12.7	8.3	13.4	.239	n.s.
Treatment in the last 30 days	46.8	58.3	44.8	.751	n.s.
Psychological					
Residential treatment	25.0	41.7	21.9	2.111	n.s.
Out-patient treatment	13.2	16.7	12.5	.154	n.s.
Depression ever in life	60.5	75.0	57.8	1.249	n.s.
Depression last 30 days	19.7	33.3	17.2	1.663	n.s.
Anxiety ever in life	61.8	75.0	59.4	1.045	n.s.
Anxiety last 30 days	42.1	41.7	42.2	.001	n.s.
Difficulties understanding ever in life [a]	37.3	58.3	33.3	2.693	n.s.
Difficulties understanding last 30 days	34.7	50.0	31.7	1.483	n.s.
Hallucinations ever in life	18.4	41.7	14.1	5.124	p<.05*
Hallucinations last 30 days	1.3	0.0	1.6	.190	n.s.
Aggression ever in life	61.8	66.7	60.9	.141	n.s.
Aggression last 30 days	27.6	50.0	23.4	3.566	n.s.
Prescribed medicines ever in life	40.0	36.4	40.6	.071	n.s.
Prescribed medicines last 30 days	30.3	25.0	31.3	.187	n.s.
Suicide thoughts ever in life	36.8	41.7	35.9	.143	n.s.
Suicide thoughts last 30 days ◦	3.9	25.0	0.0	10.716	p<.01 **
Suicide attempt ever in life	30.3	33.3	29.7	.064	n.s.
Suicide attempt last 30 days	0.0	0.0	0.0	n/a	n.s.

Notes: ◦ *Yates correction for small cells applied*

[a] *Significance Pearson chi-square = .024 / Significance Yates correction = .063*

- PARTICIPATION, INTERACTIONS AND SOCIAL ROLES

In general, attendance rates in substance abuse treatment facilities varied from 38% (residential drug-free treatment) over 34.2% (outpatient substitution treatment), 32.9% (psychiatric hospital), 30.4% (outpatient drug-free treatment), 15.2% (residential detoxification), 13.9% (general hospital and day treatment) to 7.6% (outpatient detoxification) and 6.3% (other treatment). Participants with the label 'intellectually impaired' were more often treated within a residential drug-free facility (cf. table 4.4.).

Furthermore, the majority of the participants lived in a controlled environment during the last three years. (Almost) 50% of the interviewees ever experienced episodes of serious problems with mother, father or partner. Almost 30% also indicated that they had problems with friends and over 30% with siblings. One fifth reported to have been emotionally abused, one out of ten has ever been physically abused, and almost 8% has been sexually abused. No differences were found for people with and without the label 'intellectually impaired'.

Table 4.3.: Percentages and distribution of EuropASI variables, itemized for the AAMR (2002) dimension 'adaptive behavior'

	Total (%) (n=79)	**Raven score pc ≤ 5 (%)** (n=12)	**Raven score pc > 5 (%)** (n=67)	χ^2	**Sign.**
Conceptual					
Difficulties to understand questions ◦	14.5	45.5	8.6	7.369	p<.01 **
Debts	73.4	58.3	76.1	1.650	n.s.
Money spent on drugs last 30 days	20.3	33.3	17.9	1.499	n.s.
Social					
People dependent on participant	13.9	25.0	11.9	1.448	n.s.
Future trial or sentence	32.1	33.3	31.8	.011	n.s.
Possession and dealing of drugs	71.2	66.7	72.1	.146	n.s.
Crimes against property	84.7	90.9	83.6	.384	n.s.
Crimes of violence	77.9	83.3	76.9	.242	n.s.
Other crimes	13.7	16.7	13.1	.107	n.s.
Charges for disorderly conduct, vagrancy	30.8	41.7	28.8	.791	n.s.
Charges for prostitution	1.3	0.0	1.5	.184	n.s.
Charges for driving while intoxicated	29.5	33.3	28.8	.101	n.s.
Charges for major driving violations	51.3	33.3	54.7	1.844	n.s.
Illegal activities in prison last 30 days	19.2	25.0	18.2	.304	n.s.
Practical					
Driving license	41.8	33.3	43.3	.414	n.s.
Resources from work ◦	62.0	16.7	70.1	10.193	p<.01**
Resources from allowance	13.9	25.0	11.9	1.448	n.s.
Resources from family	59.5	83.3	55.2	3.337	n.s.
Resources from illegal activities	15.2	33.3	11.9	3.616	n.s.
Resources from *VDAB*	1.3	0.0	1.5	.181	n.s.
Resources from *OCMW*	2.5	0.0	3.0	.368	n.s.

Notes: ◦ Yates correction for small cells applied

Table 4.4.: Percentages and distribution of EuropASI variables, itemized for the AAMR (2002) dimension 'participation, interactions and social roles'

	Total (%) (n=79)	**Raven score pc ≤ 5 (%)** (n=12)	**Raven score pc > 5 (%)** (n=67)	**χ^2**	**Sign.**
Ever married	25.6	16.7	27.3	.599	n.s.
Together with someone with alcohol problem	3.8	8.3	3.0	.772	n.s.
Together with someone with drug problem	21.8	16.7	22.7	.219	n.s.
Happy with how free time is spent	51.3	58.3	50.0	.291	n.s.
Outpatient detoxification illegal drugs	7.6	0.0	9.0	1.163	n.s.
Residential detoxification illegal drugs	15.2	0.0	17.9	2.534	n.s.
Outpatient substitution treatment drugs	34.2	16.7	37.3	1.929	n.s.
Outpatient drug-free treatment	30.4	25.0	31.3	.194	n.s.
Residential drug-free treatment [a]	38.0	66.7	32.8	4.945	p<.05*
Day treatment illegal drugs	13.9	0.0	16.4	2.289	n.s.
Psychiatric hospital illegal drugs	32.9	41.7	31.3	.491	n.s.
General hospital	13.9	8.3	14.9	.369	n.s.
Other treatment	6.3	0.0	7.5	.956	n.s.
Life situation last 3 years in controlled place	67.1	66.7	67.2	.001	n.s.
Serious problems with mother ever in life	47.4	58.3	45.3	6.674	n.s.
Serious problems with father ever in life	50.0	58.3	48.4	1.601	n.s.
Serious problems with siblings ever in life	32.5	50.0	29.2	2.000	n.s.
Serious problems with partner ever in life	46.8	50.0	46.2	.921	n.s.
Serious problems with children ever in life	3.9	0.0	4.6	1.613	n.s.
Serious problems with family ever in life	14.3	16.7	13.8	2.605	n.s.
Serious problems with friends ever in life	28.6	33.3	27.7	1.241	n.s.
Serious problems with neighbors ever in life	22.1	8.3	24.6	2.656	n.s.
Serious problems with colleagues ever in life	15.6	25.0	13.8	2.866	n.s.
Ever been emotionally abused	22.1	25.0	21.5	.071	n.s.
Ever been physically abused	11.7	16.7	10.8	.341	n.s.
Ever been sexually abused	7.8	8.3	7.7	.006	n.s.

Notes: [a] *Significance Pearson chi-square = .026 / Significance Yates correction = .057*

- CONTEXT

The other dimensions all include several variables, which can be considered as constituting the context against which the data should be considered. The presented variables in this section indicate in how far the participants received any treatment in one of the mentioned areas or were able to execute an occupation in prison. Almost 50% of the interviewees received medical treatment during the last six months, while only 9% received in-prison substance abuse treatment. Almost 45% stressed that work was the major source of income, although differences

were found for people with and without the label of being 'intellectually impaired' (table 4.5.).

Table 4.5.: Percentages and distribution of EuropASI variables, itemized for the AAMR (2002) dimension 'context

	Total (%) (n=79)	**Raven score pc ≤ 5 (%)** (n=12)	**Raven score pc > 5 (%)** (n=67)	χ^2	**Sign.**
Received medical treatment last 6 months	46.8	58.3	44.8	.751	n.s.
Work as major source of money last 30 d. ◦	44.9	8.3	51.5	6.008	p<.05 *
Substance abuse treatment last 30 days	9.0	0.0	10.6	1.398	n.s.

Notes: ◦ Yates correction for small cells applied

4.5. DISCUSSION

The results of the present study indicate that almost half of the participating incarcerated drug-involved offenders score definitely below average on the Raven SPM; moreover, about 15% of the total group could be labeled as 'intellectually impaired' on basis of these SPM-figures. Other studies, aimed at investigating the prevalence of people with intellectual disabilities in the general prison population, show somewhat lower rates, varying from 0% to 9.5% (for an overview, cf. Holland et al., 2002). Different explanations can be put forward to count for this wide range: cultural differences, incomplete data, the use of different assessment criteria and cut-off figures, differences in the definition of intellectual disability, expertise of the test administrators and the used method (Holland et al., 2002; McBrien, 2003). As this research considered the fifth percentile as cut-off score, the relatively high proportion of people labeled as having ID could be assigned to the use of this criterion. Another potential reason of the particularly low Raven-scores in this study is the potential bias caused by the fact that respondents may have been under influence of illegal drugs, at the time of the test administration. Moreover, the present study specifically focused on the special target group of drug-involved offenders, in which intellectual disabilities seem to be more widespread. This is supported by several research findings, indicating that 'cognitive deficits are often observed in patients with psychoactive substance use disorders' (Fals-Stewart & Schafer, 1992, p. 359). A study by McGillicuddy & Blane (1999) concluded that there is a relationship between cognitive limitations

and an increased risk of substance abuse. Other research however illustrated that alcohol and substance use rates of people with intellectual disabilities seem to be almost the same or somewhat lower as compared to figures of their non-disabled social network members and peers (DiNitto & Krishef, 1983; Edgerton, 1986; Krishef & DiNitto, 1981; Moore & Li, 1997; Westermeyer, Kemp, & Nugent, 1996), although the figures remain ambiguous (McGillivray & Moore, 2001).

Research findings concerning the most important reasons why people with intellectual disabilities use licit as well as illegal drugs are sparse, although it can be imagined that these motives are the same as for people without ID. Available data point into the direction of motives such as 'fitting in and feeling accepted' (Wenc, 1981 as cited in Greer, 1986), 'pleasure' and 'overcoming loneliness'. Degenhardt (2000) states: 'These motives might be more important for an adult with intellectual disability, because of the greater social isolation they often experience due to stigma, because of limited avenues for contact with non-disabled peers, and because of limited social skills'. The present study could support these conclusions to a certain extent: participants with intellectual disabilities have relative serious difficulties to understand questions and could therefore be easily misunderstood and/or manipulated. Within this respect, it is important to indicate that the AAMR (2002, p. 42) explicitly mentions concepts such as 'gullibility (likelihood of being tricked or manipulated) and naiveté'. Moreover, as the study ultimately suggests that there are few differences between people with and without ID regarding substance use, we could assume that both groups start using substances because of comparable reasons.

When considering other criteria, in order to define intellectual disabilities in people, of which education is an important one, the present study could not demonstrate a reliable and usable criterion. The majority of the participants dropped out early in school and using attendance rates at special education schools for instance proved to be difficult, as only about 3% of the sample went to those facilities. This could potentially mean that people are not always referred to special education services, although this could have been useful in some cases. Moreover, it could also point into the direction of the existence of a substantial group of mild intellectually disabled persons in the criminal justice system, which is not correctly diagnosed nor recognized (cf. Tymchuk et al., 2001). This obliges us to think about the importance of correctly labeling people as having an intellectual disability and identifying their support needs, without however stigmatizing them as deviant, but using legible assessment criteria in order to explore one's support needs. This seems most necessary for people with mild

intellectual disabilities. Therefore, given the fact that disability is still often based on IQ-scores (Ho, 1996), it is important to stress the assessment of other dimensions, such as those suggested by AAMR (2002), although it is not always easy to undertake this in daily practice.

This study tried to investigate in how far information obtained by administering the EuropASI could be used to broaden the view regarding people with intellectual disabilities. The findings point out that – generally spoken – all the participants seemed to experience relative serious problems within several life areas, of which drug (and to a lesser extent alcohol) use, family and social relationships, legal and psychiatric status are the most important ones. When the AAMR dimensions are considered, the majority of the participants seem to have difficulties in several areas: health problems, both physical and psychological; longstanding episodes of substance abuse; difficulties with social network members; an insecure financial situation and a long history of criminal activity and convictions. All in all, the differences between people labeled as intellectually impaired on basis of the Raven SPM and those who are not, are limited: psychological problems seem to be more outspoken for the former group. People labeled as intellectually disabled, seem to experience more difficulties to understand questions and tasks (cf. Fals-Stewart & Schafer, 1996). Only a small proportion of these people reported to have a job (in prison) and earn money. It is noteworthy that almost 70% of people labeled as 'intellectually impaired' followed residential drug-free treatment, which is substantially more than the other participants. Yet, no further information was available to investigate whether or not this treatment has been successfully finished.

This study could not demonstrate differences in criminal activities between people with and without intellectual disabilities. Recently, a limited number of studies have been undertaken addressing topics about the connection between criminal offending and people with intellectual disabilities (see e.g. Glaser & Deane, 1999; Holland et al., 2002; Lindsay, 2002; Turner, 2000). The main results can be summarized as follows: people with intellectual disability are more likely to get caught by the police and lose their way in the complex justice system. Moreover, they tend to be poor, uneducated, unemployed, young, socially deprived and male, with histories of behavioral problems and of crimes committed by other family members. The present study underpinned most of these attributes, and we could add that intellectually disabled drug-involved offenders more often have psychological difficulties (such as suicide thoughts and hallucinations) in comparison with their counterparts without disabilities. This is supported by other

research, which also stresses difficulties to correctly recognize the symptoms of mental illness, because these are often 'masked' by the intellectual disability (Dosen & Day, 2001).

The present study has some limitations. Besides the fact that only a small sample is studied, the voluntary selection of the participants on basis of informed consent could have influenced the presented results. Moreover, because self-reported data are used, people could have over-emphasized or underestimated the (in-prison) drug use. Although this paper strongly pleads for a multi-dimensional assessment of ID, the authors are aware that they have only used a single assessment tool (Raven SPM) to classify people as having an intellectual disability. By doing so, problems may have occurred. First of all, the choice of the 5th percentile as cut-off score may have overemphasized the number of people labeled as having ID. Secondly, the Raven scores could have been influenced by several external variables, beyond the control of the researchers: the respondents may have been under influence of drugs at the time of the test administration and psychological problems (such as feelings of depression and loneliness) could have negatively affected the clients' performance.

Yet, as the authors are interested in the potential practical relevance of the study, they chose to model the research as much as possible on the existing daily practice, since the Raven SPM (and/or other intelligence tests) are often already administered in (Belgian) corrections. As this paper shows that these limited data could be broadened by instruments targeting other problems (i.e. substance abuse), this could be regarded by practitioners as a time- and resources-saving possibility to implement current definitions of ID in the field. Finally, as not many significant results were found, it is quintessential to consider the results with circumspection. Nevertheless, when considered as a pilot study, the research findings suggest that there are almost no differences between participants with and without ID. Some findings seem to indicate that incarcerated people with intellectual disabilities have special needs concerning (substance abuse) treatment, predominately with regard to psychological difficulties (e.g. suicide thoughts), (in-prison) employment possibilities and special attention to make (treatment) demands well understood.

On basis of this research, the question whether or not current health and care paradigms influence the definition and assessment of drug-involved criminal offenders with and without intellectual disabilities could be answered affirmatively. Assessment instruments from substance abuse research and disability research

could be used in combination with each other, providing additional information to broaden the view on these clients. The results specifically indicate the importance of taking context-oriented variables - which are quintessential in current health and care paradigms for substance abusers and people with disabilities - into account when defining intellectual disability, especially in specific target groups such as prisoners. Relevant variables from the EuropASI domains (physical health; education and work; alcohol use; substance use, legal status; family and social relationships and psychological status) can be implemented within the five domains set forth in the AAMR (2002) definition on mental retardation: cognitive abilities; adaptive behavior; participation, interaction and social roles; health and context. This could potentially stimulate the implementation of new definitions and assessment strategies with regard to ID in correctional establishments, because the used strategy could be regarded at as a complementary and a time- and resources-saving middle course to incorporating different assessment areas.

When it comes to treatment within this respect, one has to acknowledge the need for staff training both for people working in the drug field, correctional establishments as well as for those working in services for people with disabilities. Joint initiatives could provoke a mutual exchange of expertise (Clarcke & Wilson, 1999). Up until now however, little or no research has been undertaken to investigate treatment outcome of offending clients with intellectual disabilities (Burgard, Donohue, Azrin, & Teichner, 2000). Further research is needed on this topic, including the relationship between cognitive abilities and motivation towards treatment; assessment of and matching to the most suitable type of treatment; the implementation of potential modifications to existing treatment modalities and last but not least on assessment methods used in daily practice. Because some people with intellectual disabilities are disadvantaged with respect to cognition, social skills, etc. but are not clinically labeled as being disabled, they often do not meet the criteria to be treated in facilities for people with intellectual disabilities or general mental health services.

4.6. CONCLUSION

The AAMR model and the ICF system on the classification of persons with (intellectual) disabilities, demonstrate the importance and necessity to incorporate different domains in the assessment process. Historical definitions and classifications of ID used to be primarily based on cognitive variables, measured by standardized intelligence tests. This point of view is no longer tenable because

of the importance attributed to adaptive behavior and the broader personal and environmental context. However, difficulties assessing these domains are prevalent. Intellectual functioning is a multi-facetted concept, which cannot be fully mapped on basis of standardized tests. Until more optimal assessment procedures are developed, the AAMR (2002, p. 14) state that 'although far from perfect, intellectual functioning is still best represented by IQ scores when obtained from appropriate assessment instruments'.

Due to the specific circumstances related to research in the special target group of incarcerated offenders, as mentioned before, it proved to be difficult to use widely accepted intelligence instruments (such as the Wechsler Adult Intelligence Scale, WAIS). Therefore, the Raven SPM was chosen as primary measure to classify the respondents. Yet, taking the guidelines of the AAMR model into account, we are aware that several caveats should be considered when applying a suchlike procedure.

Therefore, the indicators of intellectual functioning were expanded with information on the other AAMR domains. As the utility and feasibility of existing assessment instruments for ID, primarily focusing on adaptive behavior, were questionable in secure settings, there has been chosen to investigate whether or not important information could be gathered by means of other instruments from different disciplines. As the fields of substance abuse and disability went through comparable evolutions, from a disorder- towards a person-oriented paradigm, we tried to integrate assessment instruments from both disciplines. Although the results indicate that the incarcerated respondents in general showed several problems in functioning, these difficulties seem more outspoken for those people labeled as having ID. This pleads for the development of an integrated assessment procedure, in which intellectual functioning and adaptive behavior are investigated, within a broader personal and environmental context. Although it was not the aim to be conclusive on the topic, this paper has tried to give an impetus for developing a suchlike assessment package by combining information from different assessment instruments and allied disciplines (cf. Bielecki & Swender, 2004).

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5

Cultural Responsiveness in Substance Abuse Treatment:

A qualitative study using professionals' and clients' perspectives [4]

Due to the growing number of ethnic and cultural minority clients in substance abuse treatment during the last decades, a culturally responsive approach has become more and more imperative. In this chapter, the statements (n=1,330) of professionals (n=11) and clients (n=11) representing the substance abuse treatment centers in the specific region of Gent and its suburbs (Belgium), are analyzed. The focus is directed at the specific treatment needs of ethnically and culturally diverse substance abusing clients and the difficulties consequent to treating this target group. Possible approaches intended to overcome these difficulties are highlighted and elaborated by means of semi-structured interviews and focus groups. The participants stress the importance of an integrated approach, with special attention given to the factors that can promote or jeopardize treatment.

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5.1. INTRODUCTION

Therapeutic communities have always considered cultural diversity as an essential concept within their treatment approach (De Leon, Melnick, Schokit, & Jainchill, 1993). Currently, due to the increasing number of ethnic minority clients in substance abuse treatment in general (Finn, 1994, 1996), the need for and implementation of a culturally responsive treatment has become more urgent and widespread (Argeriou & Daley, 1997; Ellis, 1999; Kline, 1996; Terrell, 1993; Westermeyer, 1996). In this context, it is worthwhile noting that the organization of treatment centers is almost always modeled after the dominant (autochthon) culture (Lee, 1994). Research points out that ethnic minorities often fail to make use of the existing treatment facilities (Ashruf & van der Eijnden, 1996; Longshore, Grills, Anglin, & Annon, 1997) and that there is a disproportionate ethnic distribution in some treatment centers, especially in those with a high threshold (e.g. therapeutic communities) (Braam, Verbraeck, & van der Wijngaert, 1998; De Leon et al., 1993; Vandevelde, Vanderplasschen, & Broekaert, 2000). Furthermore, minority clients are less likely to successfully complete treatment (Finn, 1994, 1996) and more likely to experience specific difficulties due to typical characteristics of the (traditional) treatment system, methods and techniques (Tucker, 1985).

To cope with these difficulties, recent research has revealed the importance of taking the specific needs of minority clients and other ethno-cultural factors into account when treating culturally diverse clients (Jackson, Stephens, & Smith, 1997; Rounds-Bryant, Kristiansen, & Hubbard, 1999; Varma & Siris, 1996). Therapeutic communities and other treatment centers also share these concerns and insist on the necessity of specification. First of all, substance abuse treatment centers are not equally distributed over different cities and regions in Belgium, regardless of needs (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002); moreover it is influenced by many cultural and traditional factors. Important differences can exist – such as country of origin, religion, values and beliefs – amongst culturally diverse persons seeking help. American research focusing on alcohol abuse among people of Hispanic origin emphasized the real need for specification when identifying populations, since clients differ substantially when it comes to alcohol use and incidence, although the population itself has much in common in other respects (Rodriguez-Andrew, 1998). It is also important to draw attention to differences between individuals because of the possible diversity within as well as between ethnic groups (Cheung, 1993; Longshore, Grills, & Annon, 1999; Tucker, 1985).

5.2. AIMS

This chapter investigates if and to what extent substance abuse treatment centers are currently working in a culturally responsive way, which can be described as 'the need for program staff to play an active role in integrating the client's cultural background into the treatment process' (Finn, 1996, p. 449).
The study examines the views of clients and professionals, who daily - from different perspectives - experience these problems in treatment facilities. How they perceive and cope with the problems and which improvements they suggest. The aim is to gain information on obstacles to cultural responsiveness in substance abuse treatment (Kline, 1996; Tucker, 1985) and on methods to overcome these difficulties.

5.3. ETHNICITY VERSUS NATIONALITY

The terms '(ethnic and cultural) minority clients', 'clients with ethnically/culturally diverse backgrounds', 'ethnic cultural minorities' are used in this chapter to stress ethnic origin and culture (or ethnicity), as against nationality. Currently, nationality is largely used as an exclusion-variable to differentiate between autochthons and ethnic cultural minorities, which leads to a serious underestimation of the complexity of dealing with a culturally diverse population (Provinciaal Integratiecentrum Oost-Vlaanderen (PICO), 1999).

According to Blommaert and Martiniello (1996), there are no official numbers of ethnic minorities in Belgium and the only criterion used in official statistics is nationality. Moreover, research reveals that in some cases data based on nationality cover only half of the real number of people with another ethnic cultural origin (PICO, 1999). Cheung (1993) critically evaluates some possible indicators of ethnicity – including race, country of origin, ethnic identification and ethnic culture – and concludes that it is preferable to use several of the above-mentioned indicators rather than rely on just one.
Due to the lack of a widely used and qualitative indicator of ethnicity, it is nearly impossible to present exact data relating to substance abuse among ethnic minority groups (Khan, 1999).

5.4. METHOD

5.4.1. SAMPLE

The research was carried out in all (specialized) substance abuse treatment centers in Gent and its suburbs (Belgium). The sample of participants was comprised of 11 professionals, who were delegated by the treatment centers themselves, and 11 clients. It is important to note that each facility was represented by a professional, whereas it was impossible to recruit a client in each of the treatment centers. Although the aim was to include in the sample of professionals as many persons as possible with another ethnic and cultural background, we found only one such person.

The study focused on a population that has a Turkish, Morrocan, Tunisian or Algerian ethnical background, which reflected the distribution of these sub-groups in the general population. Gent is a relatively densely populated city with 225,000 inhabitants of which approximately 17,000 (7.6%) do not have the Belgian nationality. More than 10,000 (62.3%) of them are Turkish, Moroccan, Tunisian or Algerian (situation in January, 1997 – National Institute for Statistics).

Furthermore, this study was limited to the specialized treatment facilities; that is, substance abuse treatment centers and some social welfare and health care centers that offer specialized care and treatment for substance abusing clients (Vanderplasschen et al., 2002). It should be noted that the geographical limitation to Gent is based on the diversity and comprehensiveness of the substance abuse treatment system in this specific region. It is important to emphasize that, although the number of interviews with professionals (n=11), interviews with clients (n=11) and the focus groups (n=3) may seem small, all the treatment centers in the region were represented

5.4.2. PROCEDURE AND INSTRUMENTS

Semi-structured interviews were conducted with the professionals and clients. The interview with professionals consisted of 11 open-ended questions based on literature concerning culturally responsive treatment (Braam et al., 1998; Finn, 1994, 1996) and was administered by the author. The client interviews were based on the same questions (cf. figure 5.1.), but were slightly adapted when appropriate (Aga, 2001), and were administered by Master-level students in Educational Sciences.

Figure 5.1.: Questions used in the interview with professionals.[5]

- How would you define 'ethnic minority' clients? Do you use a specific terminology?
- How many ethnic minority clients are treated in the center where you are employed?
- Does the substance abuse treatment center where you work specifically focus its efforts on reaching more ethnic minority clients?
- Does the center where you work use a specific model or method to work with ethnic minority clients? How did this model evolve?
- Who works with the ethnic minority clients?
- Do you think you work in a culturally responsive way?
- Do the clients have a voice in the treatment plan? Do you take their questions and needs into account?
- Which bottlenecks do you perceive when working with ethnic minority clients?
- Which pathways can you suggest to overcome these difficulties? Do you actually implement them in your work?
- Do you think that the government has enough attention for incorporating ethnic minority clients in your treatment center?
- Do you know 'good' practices which can offer pathways to overcome the afore mentioned bottlenecks?

The interviewed professionals later participated in one of three parallel focus groups during which possible methods for achieving more effective treatment for ethnic minority clients were discussed in depth. A focus group with clients was also planned, but was not actually executed, as there were not enough clients willing to participate in a group discussion. By using these different sources of data collection, the obtained research material is broad and diverse.

5.4.3. DATA ANALYSIS

The interviews and focus groups were audiotaped and then transcribed. General themes were recognized in the material and ordered in a tree structure. The texts were analyzed using the qualitative computer program WinMAX98. 'The methodological aim is to identify patterns in social regularities and to understand them in the sense of controlled Fremdverstehen (understanding the other)' (Kuckartz, 1998, p. 13). From this point of view, the material can be

[5] The questions used in the interview with the clients were slightly adapted.

classified, typologies can be identified and even quantification can be made possible (Broekaert et al., 2001).

Grounded in the codification of the written material, a scheme was constructed, based on relevant literature (Braam et al., 1998; Finn, 1994, 1996). What are the most prevalent pitfalls in the treatment of minority clients, as seen from three different perspectives: difficulties regarding 'perception'; difficulties encountered in 'current treatment'; and difficulties inherent in the 'policy' of the institution and the government (cf. table 5.1.)? Introducing several subcategories and focusing in greater detail on the problematic aspects of treatment completed the scheme.
Possible pathways suggested by the professionals and clients were structured on a similar basis. The interviews were systematically reviewed and statements ('hermeneutic units') concerning one of the above-mentioned categories were added to the scheme, after which these statements were counted and compared (n=1,330).

5.5. QUANTITATIVE RESULTS

5.5.1. GENERAL RESULTS

Seven of the eleven professionals indicated the lack of an appropriate and commonly used term to describe the population of minority clients, whilst the four others did not expand on this topic. Yet the professionals seemed to agree that using ethnicity rather than nationality was a more suitable criterion for defining the group of ethnically and culturally diverse minority clients. The professionals also stated not having implemented a specific method for working with clients with ethnically/culturally diverse backgrounds. Nevertheless, the statements indicate that most centers concur with the view that it is desirable to take the special needs of minority clients into account. However, this attitude is expressed informally and without benefit of a specific treatment protocol.

Many of the statements we obtained from the professionals focused on difficulties encountered in current methods of treatment (329/1,330; 24.7%) and proposed improvements (273/1,330; 20.5%), clarifying the professionals' point of view that the *therapeutic relationship* between caregiver and client is more important than the professionals' perception of difficulties (11/1,330; 0.8%) or pathways (26/1,330; 1.9%). Also, the difficulties (30/1,330; 2.2%) and pathways (3/1,330; 0.2) associated with the policy of institutions and/or government can be seen as a less

prevailing topic in the sense that the participating professionals indicated that they have no or only little insight into and/or influence on this subject. These tendencies can be identified for clients as well. The majority of the coded statements focus on difficulties (206/1,330; 15.4%) and pathways (369/1,330; 27.7%) regarding treatment. As in the case of the professionals, perception (10/1,330; 0.7%) and policy issues (73/1,330; 5.4%) are less frequently mentioned in the clients' statements. This is the main reason why the analysis is limited to the statements concerning treatment issues. Furthermore, it is important to stress that the clients talk more about possible pathways (407 statements against 251 pertaining to difficulties), whereas the professionals express more thoughts on difficulties (370 statements against 302 on pathways) (cf. table 5.1.).

Table 5.1.: Global structure of coded segments and corresponding numbers/percentages of expressions (n=1,330).

Perspectives	**Difficulties**		**Pathways**	
	N	%	N	%
Professionals				
Perception/knowledge	11	0.8	26	1.9
Treatment	329	24.7	273	20.5
Policy	30	2.2	3	0.2
Total number of expressions	***370***	***27.8***	***302***	***22.7***
Clients				
Perception/knowledge	7	0.5	3	0.2
Treatment	206	15.4	369	27.7
Policy	38	2.8	35	2.6
Total number of expressions	***251***	***18.8***	***407***	***30.6***

5.5.2. DIFFICULTIES

Of the 329 statements, concerning the bottlenecks in the current treatment of clients from ethnically/culturally diverse backgrounds, most frequently talked about by the professionals, the main topics can be summarized as follows: roughly a quarter of the problems mentioned focus on communication problems, nearly a quarter on difficulties involving the social network of the client (e.g. reaching family, friends, peers, …) and almost a quarter of the statements involve the sometimes destructive impact of clients' cultural background on the treatment process (e.g. the perception of honor and status and the preference for short-term care). Furthermore, some 15% of the statements focus on difficulties regarding

accessibility and distribution of information together with the lack of cultural responsiveness.

Of the 206 statements most frequently talked about by the clients concerning difficulties of their treatment, more than half of the statements focus on the influence of cultural and religious background on the treatment process, especially the perception of honor and status.
Nearly 20% of the statements involve difficulties regarding accessibility and distribution of information and cultural responsiveness. Communication problems and the lack of ethno-cultural peers in treatment facilities are mentioned in respectively 12% and slightly under 8% of the statements (cf. table 5.2.).

5.5.3. PATHWAYS

Of the 273 statements, concerning possible pathways in current treatment of clients from ethnically/culturally diverse backgrounds, most frequently talked about by the professionals, the main topics can be summarized as follows: roughly 22% of the statements focus on pathways to involving the family and nearly 20% on pathways to improve communication.
Pathways to taking cultural background into account and implementing cultural responsiveness accounted for 15% and nearly 13% of the statements, respectively.

Of the 369 statements most frequently talked about by the clients concerning suggested pathways regarding their treatment, more than half of the statements focus on the influence of cultural background on the treatment process, followed by suggestions for addressing such problems as lack of staff (roughly 13%), absence of peers (more than 10%) and difficulties in involving social network members (almost 10%) (cf. table 5.2.).

Table 5.2.: Detailed structure of coded segments and corresponding number/percentages of expressions.

Perspectives	Difficulties		Pathways	
	N	%	N	%
PROFESSIONALS				
Perception/knowledge (1)	***11***	***2.9***	***26***	***8.6***
Actual treatment (2)	***329***	***88.9***	***273***	***90.3***
Lack of staff	9	2.7	16	5.8
Difficult communication	87	26.4	56	20.5
Specificity/short term	18	5.4	21	7.6
Difficulties involving family	82	24.9	62	22.7
Honor/sickness	25	7.5	20	7.3
Distribution of information	11	3.3	14	5.1
Cultural responsiveness	38	11.5	35	12.8
Influence of cultural background	40	12.1	41	15.0
Peer group	19	5.7	8	2.9
Policy (3)	***30***	***8.1***	***3***	***0.9***
Total number of expressions	***370***	***100***	***302***	***100***
CLIENTS				
Perception/knowledge (1)	***7***	***2.7***	***3***	***0.7***
Actual treatment (2)	***206***	***82.0***	***369***	***90.6***
Lack of staff	3	1.4	50	13.5
Difficult communication	25	12.1	24	6.5
Specificity/short term	25	12.1	99	26.8
Difficulties involving family	6	2.9	34	9.2
Honor/sickness	63	30.5	54	14.6
Distribution of information	22	10.6	11	2.9
Cultural responsiveness	17	8.2	22	5.9
Influence of cultural background	29	14.0	37	10.0
Peer group	16	7.7	38	10.2
Policy (3)	***38***	***15.1***	***35***	***8.5***
Total number of expressions	***251***	***100***	***407***	***100***

5.6. QUALITATIVE ANALYSIS

A more thorough qualitative analysis highlighted additional aspects that, according to the clients and/or professionals, could promote or jeopardize treatment.

5.6.1. DIFFICULTIES

The results reported above show that both professionals and clients regard communication difficulties as being of central importance. Because of the importance their culture attaches to the notions of honor and respect, most minority clients (especially the male clients) find it hard to talk openly about emotional problems. The clients themselves acknowledge this problem and regard it as important to pay attention to seemingly 'small' aspects of treatment as well rather than always focusing on major (structural) changes. An example is to occasionally using words from the client's mother tongue. In this context, it is important to note that the inevitability of communication problems does not make them any less important. Besides the technical problem of being unable to understand one another (in the sense of speaking a different language), there is also a real risk of misunderstanding.

Clients from ethnically/culturally diverse backgrounds often perceive the nature and treatment of substance abuse differently than does the (predominately Western) treatment staff. Furthermore, concepts such as status and (family) honor often have different connotations, which can conflict with present-day (Western) practices in substance abuse treatment. Clients stress that the absence of ethno-cultural peers in substance abuse treatment facilities makes it hard to maintain the effort necessary to successfully complete treatment.

5.6.2. PATHWAYS

Although there may seem to be few statements about improving knowledge of the clients' cultural background, the professionals suggested some interesting pathways. Besides traditional educational programs (such as in-service training, symposia and so forth), especially cooperation and 'networking' were seen as important ways of increasing knowledge about the cultural background of ethnic minority groups. In one of the focus groups it was suggested that different

centers (e.g. substance abuse treatment centers and centers for integration of minorities) could work together on selected 'cases'.

Both professionals and clients mention the use of interpreters as the most commonly used methods – to date – for overcoming the communication problem between staff and clients. This, however, creates new problems; for example, it brings a third person into the staff-client relationship and the argot used during treatment is not always translatable, especially when 'culturally sensitive' words and/or customs are involved. Some professionals suggest using family members and peers (even those still abusing drugs) as interpreters. These professionals maintain that whilst it would not resolve all problems, it could certainly influence the degree to which the social network was involved in the treatment, thus tackling another area of difficulty. As well as using the social network as interpreter or 'cultural mediator', some professionals also stress the importance of outreaching.

Several of the professionals point out that working through the medical dimension might facilitate the treatment of minority clients, since (emotional) problems are often expressed through physical symptoms. Furthermore, professionals indicate that most minority clients stay in treatment for a relatively short period of time and only return when absolutely necessary (for example, when experiencing problems again, often of a physical and/or practical nature).

Regarding the communication problems, clients feel that using their native language would help them to express their feelings and emotions more freely, and thus make them feel more comfortable. The employment of staff members coming from ethnically/culturally diverse backgrounds could play a major role in trying to reach the clients' social network. It could also contribute in other ways to improving the work with minority clients; for example, it enables a cross-fertilization of cultural knowledge within the team. Clients indicate that it would be preferable to have staff members from minority groups, although not all participants regard it as a real necessity. Still, ethnicity is not enough; knowledge and/or experience are required as well.

5.7. DISCUSSION

Some people maintain that ethnical and cultural origin is not of crucial importance when it comes to treating substance-abusing clients (cf. quoted professionals in Finn, 1996). The results of the presented, albeit limited, study oppose these findings. Finn (1994) gives several reasons why clients' cultural origins should be taken into account: a person's cultural background is an important aspect of his/her identity; cultural factors can have a positive and/or negative impact on treatment; the effectiveness of treatment can be diminished by ethno-cultural factors; and, lastly, being a member of a minority group can in itself be a reason to start (ab)using substances. Other researchers (De La Rosa, Vega, & Radisch, 2000) have studied the influence of the acculturation process on substance abusing behavior in African-American and Hispanic clients. Differences in substance abuse caused by a person's ethnicity and cultural background could have a major influence on how treatment should be optimally organized. An American study (Ma & Shive, 2000) reports on differences in perceived risk and reported use of substances among ethnic groups (Whites, Blacks and Hispanics), as well as on differences in preferences for specific drugs, stressing the necessity of taking these differences into account when organizing prevention and treatment. Furthermore British research on the perception of mental health centers (Dein, 1997) emphasizes the importance of considering differences in explanatory models of illness as perceived by patients and doctors with ethnically/culturally diverse backgrounds.

Although they agree on the necessity of taking ethno-cultural factors into account, the participating professionals and clients stress the importance of not organizing specific and separate treatment for minority clients, as this would isolate them from other autochthon clients. Instead, they suggest making use of one or more adapted methods and fully integrating them into the general treatment plan of other (autochthon) substance-abusing clients. These methods should take the specific needs of minority clients into account, incorporating such issues as showing respect for the client's status and sense of honor and respecting the pace at which clients feel comfortable in treatment (cf. figure 5.2.). Case management, aiming at improving co-ordination and continuity of care (Vanderplasschen et al., 2002), as well as integrated treatment systems (Broekaert & Vanderplasschen, 2003) seem to offer promising insights within this respect.

Offering staff members the possibility to enhance their knowledge of the client's cultural background can yield important advantages. Educational activities and networking with ethnically and culturally diverse communities (for example, local

community centers run by ethnic minorities) are good ways to gain knowledge of other cultures. The involvement and active participation of professionals from ethnically/culturally diverse backgrounds is extremely important, since it offers the possibility of testing certain ideas and assumptions/presumptions that might be held by autochthon staff members. From this point of view, the previous suggestion of studying some individual cases together with professionals from different backgrounds – both cultural and/or occupational – could be very interesting. Although the formal possibility (i.e. during working hours) of learning more about other cultures cannot always be extended to each and every staff member, the cross-fertilization of knowledge within the team is already a goal worth striving for.

Figure 5.2.: Possible pathways aimed at improving substance abuse treatment of ethnically diverse clients according to the participating professionals and clients.

- Making use of the medical dimension as an 'entrance' into treatment instead of forcing clients – from the outset – into disclosing emotions, feelings and beliefs.
- Short-term treatment, taking continuity of care into account.
- Making use of formal signs of professionalism (e.g. the use of medical argot) without being rude or authoritarian.
- Respecting the pace at which clients feel comfortable during treatment.
- Showing respect for the status and honor of clients (especially male).
- Treatment approaches based on 'activity' rather than on verbalizing.
- The importance of taking apparently 'small' details into account
- Trying to have ethno-cultural peers in the treatment facility.
- The necessity of explicitly enabling clients to act according to cultural and religious norms.

Despite some inevitable difficulties, involving the social network in the treatment process can be considered a promising opportunity – perhaps even the most promising – of finding an 'entrance' into treatment. Minority clients often live in relatively small and isolated communities, making the support of significant others extremely important. Case management, including outreaching activities could be used to involve these people actively in the treatment & planning process, thus breaching resistance (Siegal, Rapp, Li, Saha, & Kirk, 1997) rather than passively waiting for them. Cultural responsiveness requires action and commitment,

especially from staff members. Again, special attention should be given to the employment of minority group staff members, although there is a dearth of research on the effectiveness of ethnical and cultural congruent treatment (in which staff member and client share, as far as possible, the same ethnic and cultural background) (cf. Stanley, Lawrence, & Beny, 1997). Yeh, Takeuchi and Sue (1994) describe how Asian-American children achieved higher functioning scores when discharged from mental health centers specifically organized for the Asian community (with bilingual personnel, culturally responsive forms of treatment, etc.) than when discharged from 'mainstream' centers. Other research results also point in the direction of a positive influence (for some subgroups) on treatment effectiveness when client and staff member share the same cultural and ethnical background (Fiorentine & Hillhouse, 1999; Lopez, Lopez, & Fong, 1991).

The main question of whether these results can be generalized to include all groups of ethnically/culturally diverse people remains unanswered. Ayonrinde (1999) points out that although ethnic pairing of psychiatrist and patient can be seen as beneficial, the congruency of client and caregiver can also cause major problems; for example, staff members may be considered too much 'one of us' instead of an independent and 'objective' caregiver.

The length of time that clients spend in substance abuse treatment programs is accepted as a reliable predictor of treatment success regardless of client gender, age or ethnicity (De Leon et al., 1993). Because this factor is easily measurable and objective, it is frequently used as a criterion of treatment outcome. Although this seems most appropriate for therapeutic communities, it is also true for other treatment modalities (Shwartz, Mulvey, Woods, Brannigan, & Plough, 1997). These findings could explain why past treatment of clients from ethnically diverse backgrounds has often been unsuccessful. As mentioned earlier, ethnic minority clients are less likely to complete treatment and often remain in treatment for only a relatively short period of time (Finn, 1994, 1996). In this respect, case management could be used to enhance treatment participation and outcomes (Siegal et al., 2001).
In conclusion, both the professionals and the clients stress the importance of treating minority clients within the usual (Western) framework, but also state that special attention should be given to the clients' specific needs.

Further research is needed to elaborate the suggestions made here and to test them by practical experience (for example, in action research) and – even more importantly – to better implement the feedback from clients with ethnically and

culturally diverse backgrounds. Moreover, a thorough and comprehensive study is needed to explore the needs of clients, with special attention given to cooperative research. This involves ethnic minority clients and their social network and recovered addicts. Last but not least, the use of an unequivocal registration protocol in which other indicators besides nationality are indexed seems to offer promising advantages (Cheung, 1993).

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6

Intellectual Abilities and Motivation towards Substance Abuse Treatment in Drug-Involved Offenders:

A pilot study in the Belgian criminal justice system [6]

A sample of Belgian drug-involved inmates (n=116) completed the EuropASI, Raven SPM and CMR. The pilot results demonstrate that nearly 50% of the participating drug-involved offenders display low intellectual abilities (SPM score definitely below average). Legal difficulties, drug abuse and psychological problems are identified as most severe problem areas for the total group. The participants display low to moderately low scores regarding motivation, readiness and external reasons to stay in or leave treatment. No to very limited correlations between motivational attributes and other variables such as length of prison sentence and number of violent crimes are found. Participants with high intellectual abilities are less motivated to change and less ready to enter substance abuse treatment, compared to their counterparts with average and low intellectual abilities. Implications for treatment are discussed.

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6.1. THEORETICAL BACKGROUND

6.1.1. OFFENDER RE-ENTRY IN SOCIETY

There still is an ongoing debate on the issue of whether criminal law in general, and correctional facilities in particular, should offer punishment or treatment to offenders (McGuire, 2000; Torres, 1996). Decades of pessimistic non-belief in the possibility of sustaining criminal offenders in their re-entry into society (cf. Martinson, 1974) seem to have come to an end and offender rehabilitation is again considered crucial by practitioners, researchers and administrators (Hollin, 1999; Petersilia, 2001). In addition to this optimistic belief in the effectiveness of rehabilitation efforts, the tendency to offer treatment to criminal offenders instead of incarcerating them could also be partially attributed to socio-economic reasons in times when correctional establishments are overpopulated. This seems most prevalent for those inmates with specific needs (drug abusers, people with mental health problems, mentally retarded prisoners, ethnically and culturally diverse clients, etc.) (Brochu, Guyon, & Desjardins, 1999; Fazel & Danesh, 2002; Glaser & Deane, 1999; McGillivray & Moore, 2001; Vandevelde, Broekaert, & Van Hove, submitted).

6.1.2. SUBSTANCE ABUSE TREATMENT IN CORRECTIONAL ESTABLISHMENTS

Lang & Belenko (2000) and Harrison (2001), amongst others, refer to studies which estimate that 80% of inmates in correctional establishments are involved with drugs or alcohol, meaning that they have regularly used substances in the past or are still using them; were under the influence of drugs or alcohol during their criminal activities; committed their crimes to finance their use or were arrested and/or sentenced for drug offences. Because of the fact that substance abuse is a widespread problem in the population of criminal offenders, the criminal justice system has become an important place where substance abuse treatment can be organized and provided (Harrison, 2001), as the significance of mandated or coerced treatment clearly illustrates (Anglin & Hser, 1991; Anglin, Prendergast, & Farabee, 1998). This tendency can also be observed to a certain extent in the Belgian criminal justice system, although the provision of treatment is still in an early phase, since the current number of existing prison-based interventions is limited. According to the European Monitoring Centre for Drugs and Drug Addiction (2003) and the Belgian National Report on Drugs (Sleiman, 2003) however, the development of two more drug-free units and five more

therapeutic communities is planned. Recently (2002), two drug coordinators (one for Flanders and one for Wallonia) were appointed in order to coordinate and develop a drug policy in correctional establishments. With regard to abstinence-oriented prison-based programs, there are some pilots of drug-free departments and one drug-free program, influenced by therapeutic community principles, which has been running since 1995 (Ruiselede). Furthermore, substitution treatment and harm reduction measures are organized within correctional establishments, as well as therapeutic interventions executed by external organizations (Sleiman, 2003). Several international studies highlight the effectiveness of (coerced) treatment in criminal justice populations (Farabee, Prendergast, & Anglin, 1998; Grichting, Uchtenhagen, & Rehm, 2002), e.g. in prison-based therapeutic communities (Knight, Hiller, & Simpson, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Swartz, Lurigio, & Slomka, 1996; Vandevelde, Broekaert, Yates, & Kooyman, 2004; Wexler, De Leon, Thomson, Kressel, & Peters, 1999). However, research demonstrates that only a limited number of offenders participate in prison-based treatment programs, due to the fact that they are either not selected or they decide not to make use of the existing possibilities (White, Ackerman, & Caraveo, 2001), which emphasizes the role of motivation in substance abuse treatment. Moreover, with regard to the Belgian situation, it can be assumed that, because the available places in correction-based treatment programs, especially in the drug-free TC-like facility, are rather limited, quite a few potential clients cannot be treated when incarcerated.

6.1.3. CLIENT CHARACTERISTICS AND MOTIVATION TOWARDS TREATMENT

Nowadays, clinicians as well as researchers acknowledge the importance of motivation in effective substance abuse treatment, as motivational factors seem to predict retention in treatment, showing that high levels of motivation lead to a prolonged stay in treatment (De Leon, Melnick, Thomas, Kressel, & Wexler, 2000; Melnick, De Leon, Hawke, Jainchill, & Kressel, 1997). This could be demonstrated for different treatment modalities: long-term residential programs, such as therapeutic communities, outpatient methadone facilities and outpatient drug free programs (Joe, Simpson, & Broome, 1998), both within (De Leon et al., 2000) and outside (Melnick et al., 1997) the criminal justice system. Varieties of theoretical models, highlighting the dynamic character of motivation, have been put forward. Central to the recent concept of motivation is the distinction between extrinsic (such as legal pressure or coercion) and intrinsic motivation. The transtheoretical model, developed by Prochaska and colleagues, is possibly the most well known example (Prochaska, DiClemente, & Norcross, 1992) and

makes a distinction between five phases: pre-contemplation, contemplation, preparation, action and stabilization. These phases are not linear, but circular, which explains why most clients go through the different stages more than once. De Leon (1996) developed a recovery oriented stage paradigm, in which he applies the transtheoretical model to treatment. The 'ten stages' model, originally based on clinical and research experiences in TC settings, also proved its usefulness for other treatment modalities. Six stages (denial, ambivalence, motivation (extrinsic), motivation (intrinsic), readiness for change & readiness for treatment) are coined as pre-treatment stages, while four stages (deaddiction, abstinence, continuance & integration and identity change) are treatment-related. Recent studies demonstrate that judicial drug-involved clients (Brochu et al., 1999) and incarcerated offenders in prison-based TCs (De Leon et al., 2000) often show low and only extrinsic motivation *ab initio,* compared to their non-judicial counterparts and those clients treated in community based programs (Sia, Danserea, & Czuchry, 2000). Moreover, some researchers (Polcin, 1999) underscore the importance of taking motivational concepts into account, as judicial clients who are often legally coerced into treatment can often still be considered as 'pre-contemplators' whereas their non-judicial counterparts have often already made progress in the transtheoretical cycle.

The question whether or not client characteristics influence motivation and readiness towards substance abuse treatment has been studied by several researchers. Their findings demonstrate correlations between demographic variables, such as age, substance abuse severity and motivation for clients in substance abuse treatment facilities (Melnick et al., 1997; Rapp, Li, Siegal, & DeLiberty, 2003). In this respect, the effects of intellectual abilities on substance abuse treatment processes and outcomes cannot be ignored, as research within treatment facilities identified, for instance, that poor intellectual (neurocognitive) functioning is often erroneously misunderstood as low motivation by staff members (Fals-Stewart & Schafer, 1992). Blume, Davis & Schmaling (1999) emphasize the importance of recognizing treatment denial or defensiveness in some cases as a result of cognitive disabilities rather than a lack of motivation. Treatment services may, indeed, presuppose a relatively high degree of adaptive behavior; such as responsibility, self-knowledge and verbal capacities, which may not be sufficiently present within this particular group of people (American Association on Mental Retardation (AAMR), 2002; Fals-Stewart & Schafer, 1992). Clients have to recognize many stimuli during the initial phase of treatment which is extremely difficult for people with low intellectual abilities and which could potentially compromise the whole treatment process from the start.

6.1.4. GOALS OF THE STUDY

However, up until now, only a limited number of studies have specifically tackled the relation between motivational attributes and intellectual abilities in offender populations (Mendel & Hipkins, 2002). Therefore, it seems to be important to systematically collect more information about the substance-abusing incarcerated offender with respect to important treatment-related characteristics, (intellectual functioning and motivation), as White, Ackerman & Caraveo (2001) already demonstrated for self-identified alcohol abusers. Consequently, this paper aims at mapping client characteristics, focusing on intellectual abilities and motivation towards treatment in a population of non-treatment drug-involved incarcerated offenders.

6.2. METHOD

6.2.1. SETTING

The study was carried out in four correctional establishments (Brugge, Gent, Leuven & Merksplas), situated in Flanders, the Dutch-speaking region of Belgium. Within the Belgian criminal justice system, more than 15,000 people were incarcerated during 2002, resulting in an average daily population of almost 8,000 inmates in 34 prisons (Federale Overheidsdienst Justitie, 2003). These correctional establishments can be differentiated in three classes according to the prison's capacity. All the participating establishments in the present study can be described as *'class 1'*, which are the largest facilities with a daily population varying from 300 to 700 inmates (Directoraat-Generaal Strafinrichtingen, 1999).

6.2.2. PROCEDURE

Data were collected from 116 drug-involved inmates between November 2001 and December 2003 by means of personal face-to-face interviews, conducted by the author and trained Master-level Students in Educational Sciences. Participants were selected on the basis of two criteria: *(1)* they could be classified as drug-involved offenders, meaning that they were convicted on grounds of drug-related criminal acts and/or the prison's psycho-social service files mentioned substance abuse problems identified by prison staff members; *(2)* they were able to understand and speak sufficient Dutch to make a regular conversation possible. Lists containing the names of all eligible participants were

distributed to the researchers, after which all inmates were personally called and seen by the interviewers in order to obtain voluntary informed consent. In one prison (Merksplas), a prison social service staff member recruited the participants, using the same protocol. Due to the nature of the study, refusal rates to participate were high (around 40%). After the required signed informed consent was obtained, the researchers personally interviewed the participants. The interviews usually lasted between 1 hour and 3 hours, in some cases up to 5 hours and were conducted during one session or spread over two or more sessions.

6.2.3. INSTRUMENTS

The *EuropASI* (Kokkevi, Hartgers, Blanken, Fahner, Tempesta & Uchtenhagen, 1993) is the European adaptation of the Addiction Severity Index (McLellan, Luborsky, Woody & O'Brien, 1980), a semi-structured interview, divided into 7 life areas: physical health, education and employment, alcohol use, drug use, justice and police, family and social relationships & psychological health. It is one of the most widely used instruments in the addiction field, screening for problem severity in the domains described above. Severity ratings, which are given by the interviewer, based on critical items and client perceptions, vary from zero (no treatment needed) to nine (treatment definitely necessary in a life-threatening situation). Moreover, composite scores, identifying problems during the last 30 days per life area can be calculated, using a mathematical formula, in order to reach an equally weighted combination of items. These scores range from zero (least severe) to one (most severe) (Brochu et al., 1999). In our study, we used both the severity ratings recoded on a 1 to 5 scale (1 'not a problem' and 5 'serious problem'), because these scores also incorporate life-time events, and the composite scores, in order to specifically grasp the problem severity during the last 30 days. The reliability and validity of the ASI, within different treatment settings and for special target groups, have been demonstrated in several studies (Carise et al., 2001). Hendriks, Kaplan, van Limbeek & Geerlings (1989), demonstrated the psychometric properties of the Dutch translation of the EuropASI. Furthermore, another more recent study came to comparable conclusions, except for the subscale 'Alcohol' (DeJong, Willems, Schippers, & Hendriks, 1995).

The *Raven Standard Progressive Matrices* (Raven SPM) (Raven, 1958) is a non-verbal test to assess the general ability to reason, without taking verbal capacities or academic education into account (O'Leary, Rusch, & Guastello, 1991; Raven, 2000). According to the test developer, the Raven SPM is able to map the capacity

of a person to think in a logical and consistent way (Raven, Court, & Raven, 1988). The Raven SPM is constructed as a 60-item test, organized in five sets of 12 items. Each item consists of a main figure in which a clear-cut piece is missing. The participant has to choose the corresponding correct piece out of 6 to 8 alternative solutions. Each set, in which the items range from easy to more difficult, is based on a different rationale. The test was preferred over the Wechsler intelligence tests (e.g. WAIS – *Wechsler Adult Intelligence Scale*) because of the fact that the Raven is non-verbal, untimed, culture-unbiased, shorter and easier to administrate. The reliability of the Raven was demonstrated in several studies, identifying high correlations between the Raven and WAIS (O'Leary et al., 1991). Norms, published in the official manual, were used to assign the participants to one of the three research groups (significantly below average, average, significantly above average), which will be used as indicator for intelligence in this study.

The *Circumstances, Motivation and Readiness Scales for Substance Abuse Treatment* (CMR) is a self-report Likert-type scale, comprising 18 items (statements). It is the shortened version of the CMRS (De Leon, Melnick, Kressel, & Jainchill, 1994, pp. 1-2). The instrument is based on the recovery theory by De Leon (De Leon, 1996) and was developed on the basis of interviews with TC clients and recovery staff, followed by factor analysis. Research, based both on American (Hiller, Knight, Leukefeld, & Simpson, 2002; Joe et al., 1998) and European data (Soyez, De Leon, Rosseel, & Broekaert, submitted), demonstrated that it is possible to predict treatment results on the basis of the CMR. The client has to indicate if and to what degree he or she perceives a statement, by choosing one of the six answer possibilities (ranging from strongly disagree to strongly agree and not-applicable). The scale is divided into 3 main subscales: (1) circumstances (which can be subdivided in two scales, i.e. external influences to stay in treatment and external circumstances to leave treatment); (2) motivation and (3) readiness, each resulting in a score. Circumstances map the external pressures to stay in or leave treatment; motivation assesses the internal pressure to change; readiness measures the internal necessity for treatment (as against other options to change). The CMR also produces a total score, which is the sum of the sub-scores and which assesses 'the overall potential or willingness to enter and stay in (TC) treatment' (Melnick et al., 1997, p. 489, brackets by authors).
Reliability analysis on the CMR-data of our non-treatment drug-involved offenders revealed following Cronbach Alpha's for the three subscales and the total scale: .31 (circumstances), .80 (motivation), .87 (readiness) and .84 (total score) (cf. table 6.1.). As the Alpha score for the subscale circumstances proved to

be very low, a correlational analysis was executed on the 6 relevant items, which revealed two clusters, corresponding with the design of the test: a set of items mapping the influences to enter or stay in treatment (item 1 to 3) and one indicating the items to leave treatment (item 4 to 6) (cf. table 6.1.). Based on a reliability analysis on each separate group of 3 items, it was decided to eliminate one item in each set (item 1 and item 5). The content of both items 1 and 5 (cf. table 6.1.) are not really suited for an incarcerated population, what justifies their elimination on both substantial and psychometric grounds. The resulting reliability scores for both sets of circumstances are .37 (set enter/stay, items 2 and 3) and .43 (set leave, items 4 and 6). Since circumstances are particular for the criminal offenders in our study, we will focus on the separate scores for (1) motivation, (2) readiness, (3) the extrinsic influences to enter/stay in treatment and (4) extrinsic influences to leave treatment.

Table 6.1.: Mean circumstances, motivation and readiness scores

	Mean sumscore	*SD*	*Standard Error Mean (sumscore)*	*Mean (scale 1-5)*	*Reliability Coefficient (Cronbach a)*
CIRCUMSTANCES	18.64	3.82			.31
*External to enter/stay in treatment **	4.91	2.19	.24	2.5	.37
1. I am sure that I would go to jail if I didn't enter treatment. 2. I am sure that I would have come to treatment without the pressure of my legal involvement. 3. I am sure that my family will not let me live at home if I did not come to treatment.					
*External to leave treatment ***	4.31	1.88	.19	2.1	.43
4. I believe that my family/relationship will try to make me leave treatment after a few months. 5. I am worried that I will have serious money problems if I stay in treatment. 6. Basically, I feel I have too many outside problems that will prevent me from completing treatment (parents, spouse/relationship, children, loss of job, loss of income, loss of education, family problems, loss of home/place to live, etc.).					

Table 6.1. (continued): Mean circumstances, motivation and readiness scores

	Mean sumscore	*SD*	*Standard Error Mean (sumscore)*	*Mean (scale 1-5)*	*Reliability Coefficient (Cronbach a)*
MOTIVATION	17.12	5.06	.49	3.4	.80
7. Basically, I feel that my drug use is a very serious problem in my life.					
8. Often I don't like myself because of my drug use.					
9. Lately, I feel if I don't change, my life will keep getting worse.					
10. I really feel bad that my drug use and the way I've been living has hurt a lot of people.					
11. It is more important to me than anything else that I stop using drugs.					
READINESS	22.11	7.03	.69	3.2	.87
12. I don't really believe that I have to be in treatment to stop using drugs, I can stop anytime I want.					
13. I came to this program because I really feel that I'm ready to deal with myself in treatment.					
14. I'll do whatever I have to do to get my life.					
15. Basically, I don't see any other choice for help at this time except some kind of treatment.					
16. I don't really think I can stop my drug use with the help of friends, family or religion, I really need some kind of treatment.					
17. I am really tired of using drugs and want to change, but I know I can't do it on my own.					
18. I'm willing to enter treatment as soon as possible.					
TOTAL	58.03	12.76			.84

Notes: * *Item 1 is excluded (see text for rationale)*
** *Item 5 is excluded (see text for rationale)*

6.3. RESULTS

6.3.1. SAMPLE

Table 6.2. presents the characteristics of the participating drug-involved criminal offenders, incarcerated in Belgian prisons. Most of the participants (86%) are relatively young, being in their 20s or 30s and are Belgian nationals (83%), were never married (74%), and have been serving long prison sentences, as 57% have been incarcerated for over 49 months in total. Not surprisingly, over 66% of the participants have been arrested for drug-related offences (possession and/or dealing), but other crimes are even more prevalent as well: crimes against property prove to be the most common offence (78%), followed by acts of criminal violence (73%). Usage of drugs in prison is high, as 69% of the inmates who were incarcerated during the last thirty days (N=106) report that they have used cannabis and over 20% of them admit to having used heroin during the last month. Lifetime prevalence of regular use (more than 3 times a week or 2 days consecutively in large quantities) is high for all listed substances (cf. table 6.2.). When the EuropASI severity ratings are considered, 75% of the population can be considered as currently experiencing problems with substance use (severity score ≥ 3).

The results of the Raven SPM reveal a disproportionate distribution, as more than 47% of the participants (N=116) score definitely below average, compared to available recent norms. Moreover, about 10% of the participants could be classified as 'intellectually impaired'. When the three research groups are considered, 10% (11/110) scores definitively above average, 40% (44/110) are in the average group and 50% (55/110) are classed as definitively below average (cf. table 6.3.). School history shows a high dropout since 57,8% did not successfully finish high school.

CMR scores prove to be relatively low, in comparison to other studies using the same instrument (cf. De Leon et al., 2000). The mean score, standard deviation, standard error of the mean and Cronbach Alpha of the sub-scales and total instrument are presented in table 6.1. Over 75% of the participants are low or moderately low motivated to enter substance abuse treatment using available American norms and based on the CMR-total score (cf. table 6.2.). Standard deviations are relatively elevated for all subscales, indicating a high distribution amongst the participants (cf. table 6.1.). When the scores of the 4 subscales mapping (1) motivation, (2) readiness, (3) the extrinsic influences to enter/stay in treatment and (4) extrinsic influences to leave treatment are considered, more

specific results could be noted. Motivation and readiness turn out to be moderate (M=3.4 and M=3.2 respectively), whilst both scales mapping external influences are low (M=2.5 for influence to enter/stay in treatment and M=2.1 for influences to leave treatment).

Table 6.2.: Characteristics of drug-involved incarcerated offenders (n = 116)

Variable	Number	Percentage
Age (M = 30.6, SD = 6.7)		
18-20	5	4.3
21-30	50	43.1
30-39	50	43.1
40 and older	11	9.5
Nationality		
Belgium	96	82.8
Maghreb-countries & Turkey	16	13.8
Other European countries	4	3.5
Highest educational degree		
No degree	2	1.7
Special education	4	3.4
Basic education (usually until 12 years old)	67	57.8
Vocational training, Part time education / employment	32	27.6
≥ High school (usually12 years – 18 years and older)	10	8.7
Missing	1	0.9
Marital status		
Married	10	8.6
Never married	86	74.1
Divorced, separated or widowed	19	16.4
Missing	1	0.9
Criminal history		
Offences (registered by police)		
Drug-related (M = 3.9, SD = 10.6)	77	66.4
Fraud/forgery/theft (M = 4.7, SD = 6.4)	90	77.6
Violent crimes (M = 3.5, SD = 7.2)	85	73.3
Other (M = .4, SD = 1.2)	20	17.2
Current involvement in criminal activities		
Illegal activities last 30 days: prison (M = 3.2, SD = 8.9)	19	16.4
Still one or more pending cases ?	38	32.8
Time spent in prison (months) (M = 59.2, SD = 31.8)		
0-12 months	9	7.8
13-48 months	39	33.6
49-60 months	10	8.6
61 and more months	56	48.3
Missing	2	1.7

Table 6.2. (continued): Characteristics of drug-involved incarcerated offenders (n = 116)

Variable	Number	Percentage
Substance use		
Heroin		
Last 30 days	23	19.8
Ever in life	67	57.8
Missing	39	33.6
Cocaine		
Last 30 days	6	5.2
Ever in life	81	69.8
Missing	18	15.5
Cannabis		
Last 30 days	78	67.2
Ever in life	101	87.1
Missing	10	8.6
Amphetamines		
Last 30 days	12	10.3
Ever in life	69	59.5
Missing	36	31.0
Problem present (severity score EuropASI ≥ 3)	87	75.0
Severity ratings EuropASI (1-5 scale)		
Physical health (M = 2.1, SD =1.2, Md = 2.0)		
No problem	47	40.5
Small problem	32	27.6
Fairly serious problem	21	18.1
Serious problem	11	9.5
Extremely serious problem	5	4.3
Drugs (M = 3.3, SD =1.1, Md = 3.0)		
No problem	7	6.0
Small problem	22	19.0
Fairly serious problem	31	26.7
Serious problem	40	34.5
Extremely serious problem	16	13.8
Legal (M = 3.6, SD =.8, Md = 4.0)		
No problem	0	0.0
Small problem	8	6.9
Fairly serious problem	39	33.6
Serious problem	55	47.4
Extremely serious problem	13	11.2
Missing	1	0.9
Family / social contacts (M = 2.2, SD =1.0, Md = 2.0)		
No problem	36	31.0
Small problem	35	30.2
Fairly serious problem	29	25.0
Serious problem	10	8.6
Extremely serious problem	2	1.7
Missing	4	3.4

Table 6.2. (continued): Characteristics of drug-involved incarcerated offenders (n = 116)

Variable	Number	Percentage
Severity ratings EuropASI (1-5 scale)		
Psychological (M = 2.7, SD =1.3, Md = 3.0)		
No problem	27	23.3
Small problem	20	17.2
Fairly serious problem	34	29.3
Serious problem	17	14.7
Extremely serious problem	11	9.5
Missing	7	6.0
Motivation towards treatment (total-score CMR) **		
Low	69	59.5
Moderately low	19	16.4
Moderately high	9	7.8
High	6	5.2
Missing	13	11.2
Intellectual abilities (RAVEN SPM)		
Intellectually superior *(≥ pc 95)*	2	1.7
Definitively above average *(≥ pc 75)*	9	7.8
Average *(between pc 25 and pc 75)*	44	37.9
Definitively below average *(≤ pc 25)*	44	37.9
Intellectually impaired *(≤ pc 5)*	11	9.5
Missing	6	5.2

Notes: * all reported offences / offender are listed in the table
** based on available American norms (total score calculated on basis of all 18 items)

If the recoded ASI severity ratings are considered, legal difficulties, drug abuse, and psychological problems are identified as the most severe problem areas for the total group (mean and/or median ≥ 3). Problems related to physical health and family or social networks seem to be less important (cf. table 6.2.).

6.3.2. CHARACTERISTICS OF DRUG-INVOLVED OFFENDERS WITH LOW, AVERAGE AND HIGH INTELLECTUAL ABILITIES

- PSYCHOSOCIAL ATTRIBUTES.

The sub-groups of drug-involved offenders with regard to intellectual abilities (low, average and high intellectual abilities) do not differ significantly within one of the six relevant life areas of the EuropASI[7] measured by the

[7] Composite scores of the EuropASI life concerning alcohol use and employment are not analyzed in this article, because of difficulties related to the calculation of the composite scores. Alcohol use within prison was only mentioned by a small minority of the participants (14.7%) and in-prison work is not considered as regular employment in the EuropASI, which impeded the computation of these composite scores.

composite scores, which in general turned out to be low. In order to look at potential differences more in detail, we performed a multivariate analysis of variance (GLM-procedure SPSS 11.00), followed with LSD post-hoc tests, to investigate the relationship between intelligence and the EuropASI severity ratings. The findings show that there is a significant difference for the three groups with regard to family problems ($F(2,67)=3.7$, $p=.03$) and a trend with regard to psychological problems ($F(2,67)=2.7$, $p=.07$). The post-hoc multiple comparisons tests (LSD) indicate that offenders with high intellectual abilities have significant lower severity ratings for drug problems ($p=.04$) and judicial issues ($p=.04$) as compared to their counterparts with average scores on the Raven SPM. Furthermore, the highly intelligent participants have significantly lower severity ratings for family difficulties ($p=.01$) and problems related to psychological health ($p=.04$) in comparison with the participants with low intellectual abilities.

- MOTIVATION.

An exploratory correlational analysis on the four motivational indices, severity ratings, length of prison sentence and number of violent crimes was performed to search for relevant variables to be taken into account in further analyses involving intelligence. The results show a positive correlation between the severity of the psychological health problem with readiness (significance level .05), severity drug problem (significance level .01), severity judicial problem (significance level .01) and circumstances to leave treatment (significance level .05). As could be expected, length of prison sentence and number of violent crimes are both positively correlated with the severity of judicial problem (significance level .05 and .01). Based on these findings, the severity score for psychological health is dichotomized (score ≤ 2 and score ≥ 3) and taken into account in further analyses.
To investigate the effect of intelligence on motivation it was decided to perform a multivariate analysis of variance (GLM-procedure SPSS 11.00) with the four above mentioned CMR-related scores as dependent variables and intelligence as well as the dichotomized severity ratings for psychological health as independent variables.

A significant multivariate effect is found for the variable intelligence (Box's M $p=.14$, Wilks' Lambda $F(8,118)=2.5$, $p=.02$). Tests of between-subjects effects and pairwise comparisons with LSD revealed the following. Intelligence has an effect on motivation ($F(2,62)=5.5$, $p=.01$, R^2 adjusted=.124) with estimated

means 13 for high intelligent, 18.6 for moderate and 16.8 for low intelligent offenders; the effect on external influence to leave is close to significance level .05 (F (2,62)=2.9, p=.06, R^2 adjusted=.104) with estimated means 3.1 for high intelligent, 3.9 for moderate and 4.7 for low intelligent offenders (cf. table 6.3.).
LSD analyses reveal that highly intelligent offenders differ significantly from clients with average and low intellectual abilities with regard to motivation to change (p= .00 and p=.03 respectively) and readiness to enter treatment (p=.04 and p=.04 respectively). Furthermore, the offenders with high intellectual abilities differ significantly from their counterparts with low intellectual abilities concerning the external influences to leave treatment (p=.03).
When the interaction-effect is considered more into detail, only one trend (F(2,62)=2.5, p=.09) for interaction could be identified on the variable external influences to enter or stay in treatment. Participants with average intellectual abilities are more likely to stay in treatment if they have psychological difficulties (M=6.0) as compared to their counterparts without psychological problems (M=4.5), while offenders with low intellectual abilities are less likely to stay in treatment if they have psychological difficulties (M=4.5) as compared to their counterparts without psychological problems (M=5.4).

Table 6.3.: Effects of intelligence on motivational indices

Variable	HIGH Raven >average (n = 11)	AVERAGE Raven average (n = 44)	LOW Raven <average (n = 55)	F	R^2 adjusted	Sig.
Motivation	13.0	18.6	16.8	5.5	.124	.007
Readiness	17.8	23.0	23.0	2.4	.061	.099
External influence to enter/stay in treatment	3.7	5.2	5.0	1.6	.048	.209
External influence to leave treatment	3.1	3.9	4.7	2.9	.104	.063

6.4. DISCUSSION

This study shows that a proportion, that should not be underestimated, of the participating drug-involved offenders display low intellectual abilities, as nearly half of the total group score definitively below average on Raven's SPM. In this respect, many studies already demonstrated the relation between intellectual abilities and performing criminal acts, although the debate on the nature of this

connection is widespread (McGloin & Pratt, 2003). Moreover, the finding that about 1 out of 10 clients of the total group could be classified as intellectually impaired can have important implications, especially in the light of several studies, showing differences between (vulnerable) offenders with intellectual disabilities and other inmates (Vandevelde et al., submitted). The deprivation cycle (Van Gennep, 1983), highlighting the connection between (intellectual) disabilities and social factors, can offer important insights. Limited social resources can provoke unfavorable school careers, which results in negative achievements in related life areas (profession, employment, etc). As the results of this study illustrate, educational levels and (social) resources of the participants are low, which – in turn – could have led to further discrimination, resulting in a negative spiral in which it is difficult to distinguish predicting and resulting variables (for an another illustration of this phenomenon in the field of disability studies, see e.g. Booth & Booth, 2004). Based on the findings of our research, no conclusions can be presented as to whether intellectual abilities and criminal activities or deviant behavior, such as substance abuse, are, in general, related. What our results do illustrate is the fact that drug-involved offenders, in general, have problems in several life areas in addition to substance abuse, such as legal and psychological difficulties. These aggravating psychological problems as well as difficulties within the social network seemed most serious for offenders with low intellectual abilities, as compared to the highly intelligent participants.

This research shows that drug-involved criminal offenders display low to moderately motivation and readiness to enter substance abuse treatment. This finding is not unexpected, as other studies came to similar conclusions (De Leon et al., 2000). A possible explanation for the low scores in this study could be that the participants did not always have concrete treatment possibilities available at the time of the interview or in the near future. As mentioned above, the number of available treatment places in Belgian prisons is limited, especially in the correction-based drug-free TC-like program in Ruiselede. Therefore, we can assume that incarcerated drug-involved criminal offenders often lack a concrete short-term perspective on comprehensive in-prison substance abuse treatment, offered by prison-based therapeutic communities. It seems that the low motivation figures, reported in this study, could be partially attributed to this fact. For these clients, the use of alternative measures instead of incarceration is not always obvious, because of the severity of their criminal acts. Therefore, an increase of in-prison treatment services, such as that at Ruiselede, would be interesting, because time spent in prison could be used to tackle substance abuse and related difficulties. International research in this area demonstrated the

effectiveness of correction-based treatment, such as in-prison therapeutic communities (Vandevelde et al., 2004).

The fact that the presented data point out that intelligence has a significant effect on motivation within our sample of drug-involved offenders is an important result. Somewhat surprising within this respect is the finding that participants with high intellectual abilities are less motivated to change and less ready to enter and stay in substance abuse treatment, compared to their counterparts with average and low intellectual abilities. As other studies proved that motivational attributes are able to predict retention in treatment, which is – in turn – related to treatment effectiveness, this could have major implications. These findings offer proof for the assumption that intellectual deficits might be responsible for the misinterpretation of motivational levels in substance abusers with low intellectual abilities. There is indeed a great risk that treatment staff members misunderstand problems related to information-processing activities, which is essential at the start of treatment in order to understand specific demands, as low motivation. Since our results suggest that people with low and average intellectual abilities are more motivated than those clients with high intellectual abilities are, special attention should be paid to assess intellectual abilities and to make sure that treatment demands are well understood by all clients. This could potentially prevent early dropout in treatment for clients with specific intellectual needs. As motivation enhancing strategies proved to be effective for substance abusers in general, it is important to ask whether these strategies could be applied to people with intellectual disabilities. One might reason that because of the intellectual difficulties, those clients will have trouble reaching the phase of intrinsic motivation. However, recent research (Mendel & Hipkins, 2002) proves that the transtheoretical cycle can be successfully used in the treatment of intellectually disabled offenders. Therefore, it seems important that motivational enhancement strategies are specifically organized at the start of treatment, taking the limited information processing skills into account of those clients who display low intellectual abilities.

This study has several limitations. Due to the small number of participants, the results should be interpreted with caution. Moreover, a potential bias could have occurred because we have only studied offenders who were willing to participate in the study. We have no data about the characteristics of the offenders who refused to take part in the study, nor about their reasons for not participating. A replication of the study with a larger population sample would be interesting in order to investigate whether or not the results could be generalized for offenders

incarcerated in other correctional establishments and/or for clients following (prison-based) substance abuse treatment. Furthermore, the study relied on self-reported measures of drug- and alcohol use, which may have led to an underestimation of in-prison drug use. The research did not formally control for socially desirable responses, which may have been given because of the delicate nature of the study. In order to address some of these shortcomings, the answers on the Raven SPM were checked for their correspondence to the normal (expected) score composition, published in the official manual. Moreover, the data obtained by administering the EuropASI were double-checked on internal consistency during the interview, by summarizing the life story of the participants and controlling this with the information provided. Although we are convinced that a multi-dimensional assessment of intellectual functioning is extremely important (cf. Vandevelde et al., submitted), we chose to use a single assessment instrument to assign the participants to one of the three research groups. Pragmatic reasons, as well as the fact that IQ-scores are widely used in correctional establishments justify this option. In this respect the AAMR (2002, p.41) states: 'although far from perfect, intellectual functioning is best represented by IQ scores when obtained from appropriate assessment instruments'. Yet, it would be extremely interesting to incorporate other dimensions, associated with the assessment of intellectual functioning, such as adaptive behavior, in future research.

In summary, this study indicates that nearly 50% of the participating drug-involved offenders display low intellectual abilities (SPM score definitely below average). Furthermore, the majority of the participants display low to moderate motivation and readiness to enter substance abuse treatment. An important finding underscores the effect of intelligence on motivation: participants with high intellectual abilities are less motivated to enter and stay in substance abuse treatment, compared to their counterparts with average and low intellectual abilities. Further analyses indicated no correlations between the motivational indices used in this study and other relevant variables, such as length of prison sentence, severity of substance abuse and number of violent crimes. Because of the exploratory nature of the study and the limitations described above, these pilot results should be interpreted with caution. Yet, to a certain extent, the findings support other research, which has demonstrated that intellectual deficits might be responsible for the misinterpretation of motivational levels in substance abusers with low intellectual abilities. As other studies proved that motivational enhancement strategies might work for people with intellectual disabilities if their

special needs are addressed (Mendel & Hipkins, 2002), this finding pleads for a careful assessment of intellectual functioning in drug-involved criminal offenders.

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7

How do Drug-Involved Incarcerated and Recently Released Offenders and Correctional Treatment Staff Perceive Treatment?

A qualitative study on treatment needs and motivation in Belgian prisons [8]

The research aimed to inventory the most common problem areas and associated treatment needs of incarcerated and recently released offenders, to determine the importance of prison-based treatment and to assess the motivation of offenders towards treatment. Interviews were scheduled with representatives of three participant categories: drug-involved incarcerated offenders (n=18), recently released prisoners (n=15) and treatment staff members (n=18), resulting in 1,971 statements. Using WinMAX98, these expressions were categorized in a tree-structure, grounded in the codification process of the raw material. The results suggest that there is a difference in opinion between offenders and service providers with regard to the most important problems related to incarceration and re-entry. The findings further indicate that released offenders struggle more with problems concerning psychological status than incarcerated offenders. Therefore, the need for continuous through- and after-care is apparent, and this pleads for the necessity to assess the participants' support expectancies and taking their individual needs into account. Motivating offenders to take part in (prison-based) treatment initiatives and aftercare is an important challenge, which can be accomplished by cooperation and partnerships between the criminal justice system and community-based treatment providers.

[8] This chapter is based on an abridged version of: Vandevelde, S., Palmans, V., Broekaert, E., Rousseau, K. & Vanderstraeten, K. (submitted). *How do drug-involved incarcerated and recently released offenders and correctional treatment staff perceive treatment? A qualitative study on treatment needs and motivation in Belgian prisons.* Manuscript submitted for publication.

7.1. INTRODUCTION

Research demonstrated that many incarcerated offenders experience problems in different areas including physical health, such as transmittable diseases (De Maere, Hariga, Bartholeyns, & Vanderveken, 2000; Petersilia, 2001), alcohol and substance abuse (Inciardi, Lockwood, & Quinlan, 1993; Plourde & Brochu, 2002), mental health problems (Fazel & Danesh, 2002) and difficulties within the social network (Johnson, Selber, & Lauderdale, 1998). Consequently, the 'average' inmate – at least for the Flemish context – could be described as: young (being between 18 and 35), male, having another ethnical or cultural background, with a low socio-economic status, no job and limited education (Vlaamse Gemeenschap, 2000). Upon release, ex-offenders are often exposed to 'unemployment, loss of social standing, stigmatisation and difficulties in obtaining housing' (Helfgott, 1997, p.12). Moreover, many ex-offenders remain educationally unskilled and in some cases, they have intellectual or learning disabilities (Basile, 2002; Lindsay, 2002). Furthermore, released offenders who were addicted before the prison sentence, often start using substances again (EMCDDA, 2003; Harrison, 2001), which pleads for the importance of post-prison aftercare (e.g. Melnick, De Leon, Thomas, Kressel, & Wexler, 2001). Other problems associated with prisoner re-entry include difficulties with the social security system, poor job application competencies and the fact that minimal wage-jobs are often the only employment possibility (Petersilia, 2001; Rahill-Beuler & Kretzer, 1997).

Under impetus of the growing prison populations worldwide and the effects of evidence-based treatment interventions, rehabilitation efforts gained influence after years of little interest (Hollin, 1999). The 1970s and 1980s were indeed characterized by a firm disbelief in rehabilitation initiatives for offenders (e.g. Martinson, 1974). During the 1990s, several large-scale meta-analytic studies (e.g. Lipsey & Wilson, 1993) were carried out (for an overview, see Hollin, 1999), demonstrating the potential positive effects of treatment programmes for criminal offenders. In this respect, Cullen and Applegate (1997, p. xxvii) state: 'At least in the U.S., rehabilitation represents the only competing philosophy that has the cultural roots and legitimacy among the public to provide a 'sensible' explanation as to why correctional interventions should invest resources in offenders'. Other researchers came to a comparable point of view, underscoring the effectiveness of cognitive behavioural therapy (Allen, MacKenzie, & Hickman, 2001); the multi-systemic approach (Randall & Cunningham, 2003); relapse prevention (Dowden, Antonowicz, & Andrews, 2003) and other treatment options, such as psycho-educational interventions and skills-training (McGuire, 2000). Moreover, similar

studies have been undertaken with regard to treating specific problems in offenders, such as substance abuse (Pearson & Lipton, 1999) and severe psychiatric disorders (Steadman et al., 1999), leading to promising results.

Hollin (1999, p. 363) inventories the characteristics of effective treatment programmes for offenders: the interventions should be focused on specific target groups (e.g. high-risk offenders, substance abusers, etc.); structured, well-defined types of treatment are preferable; a cognitive treatment-component seems to lead to more successful treatment; offender responsiveness and engagement should be emphasized; it is essential that treatment is community-based or has – at least – links with the community and the programs should be carried out by trained staff members.

Given this context, the present chapter aims at exploring the needs and expectations of criminal offenders with regard to support and treatment during and after their sentence in Flemish correctional establishments. Four main questions will be addressed, using data obtained from incarcerated offenders, released prisoners and treatment staff members. First of all, we would like to describe the most common problems of (ex-)offenders and the associated need for support. Secondly, we will elaborate the topic of whether prison-based treatment during incarceration is perceived as useful by the participants. Thirdly, the concept of motivation will be investigated, aiming at providing insight in the nature of readiness for change and treatment. Fourthly, differences between the participant groups, with regard to these topics, will be further investigated.

7.2. METHOD

7.2.1. SAMPLE

Qualitative in-depth interviews were scheduled with representatives of the three participant categories: drug-involved incarcerated offenders (n=18), recently released prisoners (n=15) and treatment staff members (n=18), resulting in a total sample of 51 participants. Table 7.1. and table 7.2. give an overview of the main characteristics of the (ex-)detainees in this study. The participating treatment facilities (n=18) were categorized on the basis of main treatment focus and available interventions: education and employment (n=1), substance abuse (n=2), judicial issues (n=8), psychological health (n=2) and 'not specified' (n=5). One key professional per treatment center was selected, chosen by the service provider itself, in order to participate in the study. Interviews with all the before mentioned

key-informants were scheduled until the 'saturation point', when no additional information could be gained anymore (Maso & Smaling, 1998). Therefore, the gathered information, on basis of the interviews with a relatively small number of participants, can be considered as complete as possible.

Table 7.1.: Characteristics of the participating (ex-)offenders (n=33)

Characteristics	**Incarcerated offenders** ***(n = 18 – 54.5%)***		**Released offenders** ***(n = 15 – 45.5%)***	
	n	%	n	%
Gender				
Male	18	100.0	14	93.3
Female	0	0.0	1	6.7
Age (M=31.3; SD=8.6)				
18-20	0	0.0	1	6.7
21-30	9	50.0	10	66.7
31-40	4	22.2	2	13.3
Older than 40	2	11.1	2	13.3
Missing	3	16.7	0	0.0
Nationality				
Belgium	17	94.4	13	86.7
Other	1	5.6	2	13.3
Currently in treatment	0	0.0	12	80.0
Number of days in prison during the last month				
0-15	0	0.0	4	26.7
11-30	18	100.0	8	53.3
Not applicable *(released from prison over a month ago)*	0	0.0	3	20.0
Marital status				
Never married	10	55.6	12	80.0
Married	5	27.8	0	0.0
Divorced/separated/widowed	3	16.7	3	20.0
Substance use				
Heroin – last 30 days	3	16.7	7	46.7
Cocaine – last 30 days	1	5.6	6	40.0
Cannabis – last 30 days	15	83.3	9	60.0
Amphetamines – last 30 days	1	5.6	1	6.7
Alcohol – last 30 days	3	16.7	7	46.7
Readiness to change *				
Low motivated (-over 1SD)	3	16.7	0	0.0
Moderately low motivated (-1SD)	11	61.1	0	0.0
Moderately high motivated (+1SD)	2	11.1	11	73.3
High motivated (+over 1SD)	2	11.1	3	20.0
Missing	0	0.0	1	6.7

*Note: * Based on the URICA-scores. Because no norms were available, the mean scores and standard deviations were calculated, on basis of which the groups were differentiated*

Table 7.2.: Severity scores EuropASI (min. 0, no problem – max. 9, major problem, life-threatening situation)

	Incarcerated offenders (n=18)	**Released offenders (n=15)**
Physical health	1.5	2.0
Education / employment	2.3	3.3
Alcohol	0.6	1.3
Substance use	1.8	5.7
Legal status	3.1	4.9
Family / social relations	1.1	2.6
Psychological status	2.3	5.3

7.2.2. PROCEDURE

The participating prisoners in the study were selected within a research cohort of a larger study, which was initiated in 2000, focusing on characteristics (intellectual abilities, substance use and abuse patterns and motivational indices) of incarcerated offenders in Belgian correctional establishments. Out of 94 detainees, only those were selected which were still residing in the original correctional facility, as privacy regulations impeded a more thorough community-based (follow-up) research. Eighteen people chose to participate in the study, after signing an informed consent form. The prisoners were personally called and seen by the researchers during one moment, which took place in the lawyer's consultation offices and lasted about one to three hours. If possible, the interviews were tape-recorded and literally transcribed. Yet, due to in-prison safety regulations, a tape-recording device could not always be used. In those cases, the participants' answers were written down during and immediately after the interview, in order not to loose or distort important information.

Using the *'Sociale Kaart' [Social Map]* (Kluwer & Karel De Grote-Hogeschool, 2000), a software program which inventories the available treatment services in Flanders and Brussels, an overview of facilities, (specifically) targeting ex-detainees was obtained. A letter, stating the purpose of the study and asking for cooperation, was sent to all these service providers. After repeatedly reminder telephone calls, eighteen facilities ultimately agreed to take part in the research project by appointing a contact person. The interviews with these key professionals were carried out in the offices of the treatment providers or on a neutral place, after which the tape-recorded proceedings of these conversations were literally transcribed. Each interview lasted about half an hour to one hour.

Because of pragmatic reasons, three interviews were carried out in the form of a written questionnaire, which was sent to the key professional by e-mail.

The released offenders, who took part in the study, were selected in two treatment settings, one primarily tackling problems concerning psychological health, the other addressing problems related to re-entry in society. Due to privacy reasons, only these facilities gave permission to carry out interviews with clients, under the explicit condition that the client himself fully agreed (by means of signing an informed consent form) to participate in the study. No information about whether or not a client took part in the study nor about the content of the actual interview was revealed to the service provider or anyone else. The interviews with the released offenders, which lasted about half an hour to one hour, were tape-recorded and transcribed afterwards.

7.2.3. INSTRUMENTS

An analogous *qualitative semi-structured open-ended questionnaire*, both for the (ex-) offenders as well as for the service providers, has been developed in order to structure the interview process and to make the content of the interviews as comparable as possible (cf. figure 7.1.). These questions, based on relevant literature (Basile, 2002; Helfgott, 1997; Petersilia, 2001) were broadly formulated to prevent that the participants would be guided too much by the way the topics were raised during the interview. The interview schedule used for the treatment staff members was based on the same questionnaire, although some questions were changed or omitted.

In order to gather additional background information and to check the qualitatively obtained data, two more instruments were administered to the incarcerated offenders and the released prisoners. The *EuropASI* is the European version of the *Addiction Severity Index (ASI)* (Hendriks, Kaplan, van Limbeek, & Geerlings, 1989). It is constructed as a semi-structured interview focusing on seven areas: physical health; education and work; alcohol use; substance use; legal status; family and social relationships; and psychological status. Problem severity scores for these seven domains are rated by the interviewer (based on the gathered information and subjective perceptions of the client). The severity ratings vary from 0 (no treatment needed) to 9 (treatment definitely necessary in life-threatening situation) (Kokkevi et al., 1993). Several studies have investigated the reliability and validity of the ASI and the EuropASI and came to positive conclusions for several specific target groups (including prisoners) and a variety of

treatment settings (Carise et al., 2001; DeJong, Willems, Schippers, & Hendriks, 1995; Hendriks et al., 1989).

Figure 7.1.: Questionnaire - version for the incarcerated offenders (1) and released prisoners (2)

1. How long did your most recent prison sentence last ?
2. How many times have you been convicted to incarceration and for which offences ?
3. Have you been released under certain conditions and if so, which are these terms ?
4. Which problems did you experience during your incarceration (1) and since your release (2) ?
5. Which problems were tackled by the prison-based treatment services ?
6. What are your needs regarding in-prison treatment ?
7. If you have already followed prison-based treatment, did you successfully maintain this program ? Have you already (successfully) followed treatment outside prison ?
8. If you dropped out early, which were the main reasons ?
9. Do you think it is important to receive treatment in-prison and which problems are most urgent, in your opinion ?
10. Which were your main incentives for starting (prison-based) treatment ?

The *University of Rhode Island Change Assessment to Measure Motivational Readiness to Change (URICA)* is a 32-item self report scale to measure motivation and readiness towards change. Unlike other instruments, such as the *Circumstances, Motivation, Readiness and Suitability Scales (CMR(S))*, which psychometric properties have recently been subject to both American and European research (De Leon, Melnick, Kressel, & Jainchill, 1994; Soyez, De Leon, Rosseel, & Broekaert, submitted) and the *Texas Christian University (TCU) Motivation for Treatment scale* (cf. De Weert-Van Oene, Schippers, De Jong, & Schrijvers, 2002), the URICA is not exclusively designed for research in the addiction area. The URICA was constructed as a four-factor model (pre-contemplation, contemplation, action and

maintenance) based on the Transtheoretical Model of Change, developed by Prochaska & DiClemente (Prochaska, DiClemente, & Norcross, 1992). Besides measuring the readiness to change, it is also possible to differentiate clients on basis of the phase in which they can be currently situated. A limited reliability analysis on our data showed a Cronbach Alpha of .86 (total scale, 32 items), .50 (pre-contemplation), .78 (contemplation), .87 (action) and .89 (maintenance). Because of the low Alpha score for one subscale (pre-contemplation), we only used the total 'readiness to change score', based on all items.

7.2.4. ANALYSIS

- QUALITATIVE CODING PROTOCOL

The transcribed interviews were analyzed by means of the qualitative software package WinMAX98 (Kuckartz, 1998). WinMAX98 is embedded in social interactionism and is based on the theory of Weber and Schütz. It considers reality as a social construction, which can be categorized (Vandevelde, Vanderplasschen, & Broekaert, 2003). Although it must be taken into account that WinMAX98 was initially based on Weber's theory of 'ideal types', it uses - like most other qualitative research software packages - a 'code and retrieve' algorithm which can be applied to different theoretical and methodological contexts (Kelle, 1997).

The first step in the analysis process comprised of the identification of 'hermeneutic units' which can be described as the 'smallest meaningful' basic components within a text. In order to grasp the global content of these units, two separate preliminary coding tree-structures were developed by two independent researchers on basis of three interviews. Following thorough discussion, the two independent tree-structures were integrated into a communal one. By comparing and discussing the coding process for each hermeneutic unit, both researchers gradually refined and attuned the definitions of categories and subcategories. During the following phase of the analysis, the researchers coded all hermeneutic units together as a team according to the categories of the integrated tree structure, in order to maximize the reliability and validity of the coding process. By doing so, nine main coding categories were identified, grounded in the codification process of the raw material (cf. table 7.4.):

1. *general information*, referring to all data related to the personal life of the participants;

2. *treatment/support needs*, identifying which help the participants desire, inside as well as outside correctional establishments;
3. *importance of prison-based treatment*, focusing on the main interests attached by the participants to in-prison treatment;
4. *contact with treatment services*, referring to the experiences people had or are still having with service providers;
5. *drop-out*, exploring the reasons for not successfully ending treatment;
6. *most suitable treatment*, clarifying the benefits of a specific treatment modality for a client;
7. *motivation*, focusing on the incentives to start or leave treatment;
8. *gateway*, identifying which problem should be tackled first;
9. *problems*, inventorying all difficulties experienced inside and outside prison.

These main categories were further divided in subcategories, mainly corresponding with the before mentioned life areas of the EuropASI (cf. table 7.2.) and some specific subcategories per main coding category: the categories *problems* and *treatment/support needs* are further sub-categorized as *inside* and *outside* prison and the EuropASI domains; the category *importance of prison-based treatment* has the subcategories *positive* and *negative* attitude, supplemented with the EuropASI areas; the category motivation is sub-categorized as *extrinsic* and *intrinsic*, completed again with the EuropASI life domains (cf. tables 7.5., 7.6. and 7.7.). Because of the comprehensiveness of the data and the main research questions of the chapter, there has been chosen to focus only on these four above mentioned topics from three points of view (incarcerated, released offenders and service providers): what are the most important problems incarcerated and recently released offenders struggle with, which are their main treatment and/or support needs; what is the importance of prison-based treatment and how motivated are people to enter prison-based treatment facilities? Differences between the participant groups, with regard to these questions, will be studied more in detail.

- QUANTITATIVE ANALYSES

The qualitative coding protocol and the resulting tree structure of codes in WinMAX98, led to the development of two databases in SPSS 12.0 (Statistical Package for the Social Sciences), on which further statistical analyses were performed. The first, 'qualitative', database comprised of the 'raw' hermeneutic units (statements) by the three participant groups, itemized on basis of 4 main variables, grounded in the qualitative coding process (n=929):

(1) **Identity**: anonymous code of person who expressed the statement
(2) **Group**: information whether the statement was expressed by a detainee, released offender or treatment staff member
(3) **Main category**: category code attached to the hermeneutic unit (problems, treatment/support needs, importance prison-based treatment and motivation)
(4) **Subcategory**: relevant subcategory code attached to the hermeneutic unit (inside vs. outside prison and intrinsic vs. extrinsic)

A second 'quantitative' database consisted of the information obtained by the EuropASI and the URICA and therefore was only applicable on the inmate and released offender populations (n=33). The main variables based on these instruments (severity scores and readiness to change measure) were enlarged by data from the first database, i.e. the number of statements each of the respondents expressed with regard to the main and sub-categories. Furthermore, some additional variables were calculated, such as the number of mentioned problem areas per participant.

The first three research questions, aiming at providing insight in the nature of the participants' statements on problems areas, treatment needs, importance of prison-based treatment and motivation will be primarily based on the 'qualitative' database and the tree structure in WinMAX. Crosstabs are the main statistical techniques used for this descriptive analysis (cf. tables 7.4., 7.5., 7.6., and 7.7.)

With regard to the differences between the participant groups, both databases were utilized and integrated. The 'quantitative' dataset enabled us to compare the client populations, i.e. current detainees and released offenders. Several binary logistic regressions were performed with the dichotomous variable 'group' (0=incarcerated offender, 1= released offender) as dependent and selected relevant combinations of the EuropASI-, URICA-scores and number of statements on specified codes as independent variables (cf. table 7.3.). The main reason to select logistic regression in this chapter above a discriminant analysis is the fact that not all the predictor variables are normally distributed. However, due to the small sample, these quantitative results should be interpreted with caution and could only be considered as exploratory findings.
The 'qualitative' database made it possible to compare the number of expressions between the different participant groups. Crosstabs were used for these analyses.

This technique was preferred above a log-linear analysis and chi-square tests, because our data cannot be regarded as independent, which is the basic assumption to test hierarchical log-linear models and to use chi-square tests.

Table 7.3.: Binary logistic regression analyses for different influencing variables on client category (0=incarcerated offender / 1=released offender) †

	Odds Ratio	95.0 C.I. Lower	95.0 C.I. Upper
ANALYSIS 1 – General results			
Model χ^2=22.585, p=0.000, R^2=.696, total accuracy=87.1%			
Motivation (URICA 'Readiness to change'-score)	3.433***	1.372	8.592
Total number of expressions on 'problems'	1.029	.783	.353
Total number of expressions on 'importance prison-based treatment'	.703	.348	1.418
Total number of expressions on 'treatment needs'	.603	.305	1.190
Total number of expressions on 'motivation'	1.911	.781	4.675
ANALYSIS 2 – Problems (based on EuropASI) ‡			
Model χ^2=23.588, p=0.000, R^2=.683, total accuracy=87.9%			
EuropASI severity score education/employment	.789	.340	1.830
EuropASI severity score alcohol	1.978	.702	5.573
EuropASI severity score substance use	1.337	.894	2.000
EuropASI severity score legal status	2.031	.770	5.361
EuropASI severity score	1.924**	1.022	3.620
ANALYSIS 3 – Problems (based on number of expressions)			
Inside prison •			
Model χ^2=9.388, p=0.052, R^2=.331, total accuracy=72.7%			
Number of expressions on judicial problems	.616	.298	1.272
Number of expressions on problems with family/social network	.362*	.118	1.112
Number of expressions on psychological problems	2.146*	.956	4.813
Number of expressions about 'no problems'	.222*	.045	1.091
Outside prison ∂			
Model χ^2=23.113, p=0.000, R^2=.673, total accuracy=84.8%			
Number of expressions on problems with education/employment	5.026	.721	35.014
Number of expressions on judicial problems	.006*	.000	1.188
Number of expressions on psychological problems	5.151**	1.402	18.929
Number of expressions on 'other' problems	8.834*	.844	92.438

Table 7.3. (continued): Binary logistic regression analyses for different influencing variables on client category (0=incarcerated offender / 1=released offender)

	Odds Ratio	95.0 C.I. Lower	95.0 C.I. Upper
ANALYSIS 4 – Motivation (based on number of expressions) £			
Model χ^2=8.193, p=.042, R^2=.294, total accuracy=69.7%			
Number of expressions on judicial extrinsic motivation	1.539	.618	3.835
Number of expressions on social extrinsic motivation	.519	.115	2.338
Number of expressions on 'other' intrinsic motivation	9.550*	1.004	90.840

* p<.10
** p<.05
*** p<.01

Notes:
† the presented logistic regressions models are good to acceptable (models) and have a good fit. With regard to analyses on 'importance of prison-based treatment' and 'treatment needs', no acceptable models could be generated
‡ the predicting variables 'severity ratings health and family and social problems were excluded from the analysis because they did not significantly contribute to the model
• the predicting variables 'number of expressions on physical, education, drugs, other and general problems' were excluded from the analysis because they did not significantly contribute to the model
∂ the predicting variables 'number of expressions on physical, drugs, family and no problems' were excluded from the analysis because they did not significantly contribute to the model
£ the other predicting variables with regard to the number of expressions on motivation were excluded from the analysis because they did not significantly contribute to the model

7.3. RESULTS

7.3.1. GENERAL RESULTS

When the main categories are considered, the participants *in globo* talked most about the problems incarcerated and released offenders experience inside and outside correctional establishments (476/1,971, 24.2%), followed by statements about previous and current contacts with service providers (363/1,971, 18.4%); general information (270/1,971, 13.7%); gateways into treatment (194/1,971, 9.8%); importance of prison-based treatment (182/1,971, 9.2%); motivation (148/1,971, 7.5%); treatment and support needs (123/1,971, 6.2%); drop-out (116/1,971, 5.9%) and most suitable treatment (99/1,971, 5%) (cf. table 7.4.).

If the participating sub-groups are more closely looked upon, no major differences could be observed between the released and incarcerated offenders. Each of both groups expressed about one third of the statements (released offenders –

585/1,971, 29.7%; incarcerated offenders – 598/1,971, 30.3%). Consequently, the treatment staff members are responsible for 40% of the expressions (788/1,971). An obvious finding is the importance all the participants attach to the category inventorying the most common problems (released offenders – 143/585, 24.4%; incarcerated offenders – 127/598, 21.2% and treatment staff – 206/788, 26.1%). Furthermore, the proportions of expressions per coding category of the released and incarcerated offenders show almost identical distributions, highlighting the importance of previous and current contact with treatment services (released offenders – 95/585, 16.2%; incarcerated offenders – 126/598, 21.1%) and general information (released offenders – 113/585, 19.3%; incarcerated offenders – 90/598, 15.1%). Besides about problems, treatment staff members talked most about previous and current experiences with treatment services (142/788, 18.0%) and finding the most suitable treatment (99/788, 12.6%) (cf. table 7.4.).

As could be expected from these descriptive analyses, a binary logistic regression, using the total number of expressions per client category and the URICA-readiness to change scores as independent variables showed no differences between the two client groups with regard to the total number of expressions per main coding category (cf. table 7.3., analysis 1).

The following paragraphs specifically tackle the main research questions of this paper. Each topic will be elaborated from the viewpoint of released and incarcerated offenders and treatment staff members.

Table 7.4.: Number of expressions per main category for the total group and the sub-groups (n=1,971)

	Number of expressions		
	N	**% within subgroup of participants**	**% within total group (N=1,971)**
Total number of expressions			
General information	270	n/a	13.7
Treatment/support needs	123	n/a	6.2
Importance of prison-based treatment	182	n/a	9.2
Contact with treatment services	363	n/a	18.4
Drop-out	116	n/a	5.9
Most suitable treatment	99	n/a	5.0
Motivation	148	n/a	7.5
Gateway	194	n/a	9.8
Problems	476	n/a	24.2
Total	**1,971**	**n/a**	**100.0**

Table 7.4. (continued): Number of expressions per main category for the total group and the sub-groups (n=1,971)

	Number of expressions		
	N	**% within subgroup of participants**	**% within total group (N=1,971)**
Released offenders			
General information	113	19.3	5.7
Treatment/support needs	55	9.4	2.8
Importance of prison-based treatment	44	7.5	2.2
Contact with treatment services	95	16.2	4.8
Drop-out	22	3.8	1.1
Most suitable treatment	0	0.0	0.0
Motivation	44	7.5	2.2
Gateway	69	11.8	3.5
Problems	143	24.4	7.3
Total	**585**	**100.0**	**29.7**
Incarcerated offenders			
General information	90	15.1	4.6
Treatment/support needs	68	11.4	3.5
Importance of prison-based treatment	65	10.9	3.3
Contact with treatment services	126	21.1	6.4
Drop-out	23	3.8	1.2
Most suitable treatment	0	0.0	0.0
Motivation	39	6.5	2.0
Gateway	60	10.0	3.0
Problems	127	21.2	6.4
Total	**598**	**100.0**	**30.3**
Treatment staff			
General information	67	8.5	3.4
Treatment/support needs	0	0.0	0.0
Importance of prison-based treatment	73	9.3	3.7
Contact with treatment services	142	18.0	7.2
Drop-out	71	9.0	3.6
Most suitable treatment	99	12.6	5.0
Motivation	65	8.2	3.3
Gateway	65	8.2	3.3
Problems	206	26.1	10.5
Total	**788**	**100.0**	**40.0**

Table 7.5., 7.6. and 7.7. give a detailed overview of the number of statements expressed by each of these participant groups with regard to the relevant coding categories, which constitute the basis for the previously mentioned research questions (the relevant category is mentioned between brackets). The most important research findings will be illustrated by literally transcribed citations.

7.3.2. COMMON PROBLEMS AND ASSOCIATED NEED FOR SUPPORT ('PROBLEMS' AND 'TREATMENT NEEDS')

Of the 143 statements about problems mentioned by the released offenders, almost half concern difficulties within the correctional establishment, whilst the other half focus on problems outside prison. The most common problems talked about by the released offenders include judicial problems, especially the lack of trust in prison-based treatment staff and psychological difficulties (*inside* prison) and problems concerning housing, administrative difficulties, employment and psychological status (such as suicide thoughts and attempts) (*outsid*e prison).

'And they (prison staff members) promised me that I could go to a crisis center the following Monday. They have told me that three times. No, after all has been said and done, I have spent twelve months and some days in prison.' (released offender)

Social problems, including feelings of loneliness, and the risk for relapsing into alcohol or substance abuse are also problems that could occur upon release from prison. When considering the related treatment needs more in detail, a noteworthy finding is that about one fifth of the expressions mentioned by the released offenders in this respect state that there are no treatment needs whatsoever inside prison. Once released from prison, the most common support needs focus on help with housing and administrative problems.

'I have neglected many things and I did not do the things I had to do, such as [paying] the rent. So I have lost my house as well.' (released offender)

Of the 127 statements about problems mentioned by the incarcerated offenders, 74% deal with in-prison problems as against 26% concerning difficulties outside correctional establishments. Again, the participants most commonly talked about in-prison problems concerning legal status, which includes the lack of trust detainees have in prison-based service providers as they fear that confidential information is not properly handled.

'I cannot speak with anybody about my personal problems here in prison, because I do not have confidence in prison staff members. (…) Everything you say here will be passed on to other people and is used against you. I do talk with staff members from outside.' (incarcerated offender)

Furthermore, prevalent difficulties include social problems, such as feelings of loneliness, the lack of friends and family to talk with and little or no in-prison

visits, administrative problems and psychological difficulties (*inside* prison) and legal, social and psychological problems (*outside* prison). There are also a number of statements about the fact that the incarcerated offenders experience no problems in prison. When related treatment needs are considered, 20.6% of the statements mention that incarcerated offenders do not have treatment needs within correctional establishments. A somewhat lower figure (14.7%) was found with regard to treatment outside prison. The majority of needs upon release focus on support with employment, the importance of outpatient treatment and housing difficulties, which all relate to the re-integration in society.

'I fear the day that I will be free. I fear that I will not be able to adapt to society. I want to leave the 'milieu' and have a normal life in a regular family, but I am afraid. I really struggle with that.' (incarcerated offender)

A binary logistic regression using the EuropASI severity scores as independent variables showed that released offenders are more likely to experience psychological problems as compared to the incarcerated offenders (OR=1.924, $p<.05$) (cf. table 7.3., analysis 2). No other differences, based on the EuropASI-scores were found. Binary logistic regressions with the number of expressions on the specified problem subcategories inside prison as independent variables demonstrated that released offenders seem to report more psychological difficulties (OR=2.146, $p<.10$) and talk less about problems with social network and family members (OR=.362, $p<.10$) and the fact that they do not encounter problems (OR=.222, $p<.10$), compared to the incarcerated offenders (cf. table 7.3., analysis 3). With regard to problems outside prison, released offenders more frequently mentioned psychological difficulties (OR= 5.151, $p<.05$) and 'other' problems (OR=8.834, $p<.10$) whilst they less talked about judicial difficulties (OR=.006, $p<.10$) (cf. table 7.3., analysis 3).

Of the 206 statements about problems mentioned by the treatment staff members, 32.5% deal with difficulties inside prison, as against 67.5% outside prison. The most prevalent problem areas can be summarized as follows: social problems, such as loosing contact with the 'outside' world and loneliness, psychological difficulties, especially depression, and problems with housing and administration (*inside* prison) and problems concerning the reintegration process into the community, such as taking care of administrative formalities (e.g. social security), the (perceived) high threshold towards treatment, housing problems and language problems (in case of ethnically diverse offenders) (*outside* prison).

'People with a label have difficulties in obtaining employment and housing. We hear stories that landlords ask for a testimonial of good conduct if (released offenders) want to rent a house. This is not legal, but it happens.' (treatment staff member)

'They have to re-adapt to society; they have to learn to cope with prompt societal changes. I'll give you an example: someone who has been incarcerated for five years is released and he wants to take the train or bus. In the mean time, however, the whole system has been changed or the bus stop location has been altered. These are small things, but people struggle with that.' (treatment staff member)

7.3.3. THE IMPORTANCE OF PRISON-BASED TREATMENT ('IMPORTANCE PRISON-BASED TREATMENT')

Of the 35 statements about the importance of prison-based treatment mentioned by the released offenders, 88.6% are definitely in favor of treatment services within correctional establishments. In 28.6% of the cases, no additional information is provided as to why in-prison treatment is useful. Reasons for advocating prison-based treatment can be found within the judicial domain, e.g. supporting the detainee with developing a rehabilitation plan. The need for in-prison treatment is also prevalent with regard to alcohol and substance use, such as the provision of a drug-free wing, as well as with psychological problems. On the other hand, 11.4% of the released offenders' statements express a negative attitude towards prison-based treatment.

'People who struggle with a drug problem (could profit from help offered) by a staff member from an ambulant treatment center, which makes it possible to talk with somebody.' (released offender)

Of the 41 statements about the importance of in-prison treatment mentioned by the incarcerated offenders, 90.2% indicate a positive attitude. Similar to the released offenders, prison-based treatment is primarily considered as useful with regard to problems associated with legal status, such as supporting and preparing the offender not to relapse into criminal behavior. Social problems and difficulties related to administrative formalities as well as alcohol and substance use are other reasons advocating the usefulness of providing prison-based treatment to incarcerated offenders.

'I think it is very important to have a good probation plan, so that you are prepared for the life outside.' (incarcerated offender)

All 51 statements about the importance of prison-based treatment expressed by the treatment staff members, indicate the undivided positive attitude of service providers towards the provision of in-prison treatment. Almost half of the expressions focus on the treatment for problems concerning administrative formalities and housing. In this respect, statements also indicate the usefulness of cooperation between prison- and community-based service providers, e.g. to guarantee continuity of care. Besides the previously mentioned problem areas, there is also primarily attention for treating and supporting clients with social and psychological problems.

'It is very important that the prison authorities support treatment initiatives. There has to be continuity between (treatment and support) in prison and external treatment. I particularly expect positive results from a potential prison-based therapeutic community, with a half-way house afterwards.' (treatment staff member)

7.3.4. MOTIVATION ('MOTIVATION')

Of the 43 statements about motivation mentioned by the released offenders, 41.9% deals with extrinsic as against 58.1% tackling intrinsic motivation. The main extrinsic reasons why people go into and maintain treatment are related to one's legal status. Especially conditions associated with being released from prison are considered as quintessential in this respect. Intrinsic motivation is often explained in rather vague terms, such as 'wanting to do something for oneself' or 'the fact that one still wants to make something out of his/her life'.

'I have followed treatment for a period of three months, because it was mentioned in my conditions that it had to be three months. (…) After three months, I have left the program, although the trajectory was not completed yet. But I could not cope with it any longer. (…) Because it was too hard there, too confronting.' (released offender)

Of the 37 expressions about motivation mentioned by the incarcerated offenders, 54.1% concern extrinsic motivation, whilst 45.9% go into intrinsic motivation. Almost all the expressions focusing on extrinsic motivation take the legal status into account: detainees indicate to start or maintain treatment to be released sooner or because they do not want to return to prison after the current sentence. Family or social network pressure is also considered as an important extrinsically motivating factor when it comes to starting and persisting in treatment. Intrinsic

motivation is related to treatment for substance and alcohol abuse problems and to support for problems associated with family or the broader social network.

'I have seen my daughter growing up, while I was imprisoned, and believe me, that really hurts. (…) That has been a reason to keep strong.' (incarcerated offender)

A binary logistic regression with motivation and number of expressions per main category indicated that released offenders display a significantly higher motivation to change as compared to the incarcerated offenders (OR=3.43, p<.01) (cf. table 7.3., analysis 1). Furthermore, released offenders seem to report more expressions with regard to 'other' intrinsic motivation (OR=9.550, p<0.10) (cf. table 7.3., analysis 4).

Of the 60 statements about motivation mentioned by the treatment staff members, 65% concerns extrinsic motivation as against 35%, which tackles intrinsic motivation. The main topic related to extrinsic motivation is legal status, similar to the findings for incarcerated and released offenders. Other reasons, however mentioned in only a small number of statements, include pressure from the partner or parents and the fact that one can leave the correctional establishment, e.g. to follow outpatient treatment sessions. Intrinsic motivation is mentioned in fewer statements and is primarily related to the fact that 'people want to change their life' and 'learn something new while it is still possible'.

'The persons we see here are usually under judicial conditions. So, many people not just want, they have to (follow treatment).' (treatment staff member)

'I am convinced that there are people who are confronted with themselves and who will choose a different road at that time.' (treatment staff member)

7.4. DISCUSSION

The most common problems mentioned by the incarcerated and recently released offenders primarily address psychological difficulties and problems associated with judicial issues, the social network and family relations. When these results are looked upon more closely, recently released offenders most talked about judicial issues, psychological problems and topics related to social relationships (*inside* prison) and 'other' problems (such as housing and administrative formalities), employment and education and psychological

problems (*outside* prison). The incarcerated offenders' statements most commonly dealt with judicial issues, family and social relationships and 'other' problems (*inside* prison) besides the fact that no problems are present, judicial issues and alcohol and substance use as well as topics associated with education and employment (*outside* prison). These results are partially in accordance with the EuropASI severity scores (cf. table 7.2.), indicating that released offenders show elevated figures with regard to substance abuse, psychological problems and legal status. For incarcerated offenders, legal issues, difficulties with education and employment as well as psychological problems are most stringent. Furthermore, a finding, based on the EuropASI-severity scores seem to indicate that incarcerated offenders experience less problems as compared to recently released offenders. This distinction is primarily relevant for psychological problems. Several explanations could be put forward to account for this difference: within prison, people could be described as 'developmentally frozen' (Zamble & Porporino, 1987 as cited in Helfgott, 1997), deprived of most of their responsibilities; correctional establishments are 'tough' environments, in which it is not easy to disclose personal feelings, especially not for inmates with special needs, which could have led to an underestimation of in-prison problems (Greer, 2002); quite some released detainees have already (unsuccessfully) followed several treatment programs (Cullen, 1997), hence their feelings of disbelief and disappointment in treatment; and whilst not always considered ideal by inmates – as this paper suggests – prison-based support opportunities are often more easily and faster accessible in comparison to community-based treatment facilities, since it takes place at the very moment of incarceration (Staton, Leukefeld, & Webster, 2003). Moreover, incarcerated offenders indicate that community-based treatment, mostly imposed within the framework of probation, 'freedom under conditions' or 'conditional release', often merely is chosen in order to avoid or conclude an ongoing prison sentence.

Hence, question marks could be placed with regard to the real motives for which clients start treatment, and it could be imagined that the received support does not always correspond to the real needs of incarcerated and released offenders. Evidence for this could be found in the comparison of statements expressed by the incarcerated and recently released offenders on the one hand and those stated by the treatment staff member on the other. Service providers primarily mention housing difficulties and administrative formalities as main problems, whilst the offender group mostly talked about psychological and judicial difficulties. Apparently, both groups have dissentient views upon problems of offenders inside and outside prison, which pleads for a careful assessment of problem areas

and associated support and treatment needs as perceived by the clients themselves. Abundant research regarding several problems including substance abuse, sexual offences and housing difficulties, has shown that supporting released offenders the first months after their sentence is very important (Basile, 2002; Butzin, Martin, & Inciardi, 2002; Hiller, Knight, & Simpson, 1999; McGrath, Cumming, Livingston, & Hoke, 2003; Rahill-Beuler & Kretzer, 1997). During this essential after-care period, it is not enough to only address the more obvious, often pragmatic, problems, such as employment but it is quintessential to respond to each individual's own needs (Rahill-Beuler & Kretzer, 1997).

After analysis of the statements about treatment needs inside prison of both incarcerated and recently released offenders, we found that quite some expressions indicated that there were no treatment needs whatsoever. This somewhat surprising finding is not supported by the results of other studies (Mason, Birmingham, & Grubin, 1997; Petersilia, 2001; Van Haegendoren, Lenaers, & Valgaeren, 2001). This could be due to the small sample size used in the present exploratory study.
At the same time, our own statement that the provision of prison-based treatment is generally considered as very important by our three research groups seems to contradict the previous result. Several possible explanations could be put forward. Although treatment is generally considered as very important, many participants do not think of themselves as potential clients. In this respect, these people can be described as 'pre-contemplators', meaning that they do not consider themselves as experiencing serious problems, which is underpinned by the low URICA-scores, especially for the incarcerated offenders. Moreover, other potential reasons include the preponderance of previous personal negative treatment experiences; the fact that incarcerated offenders are too much familiarized with the negative prison counter-culture (Helfgott, 1997), which impedes them to disclose own support needs; and consequently the finding that detainees and recently released offenders have lost connection with the changing world around them, which could provoke a negative belief in future personal development.

In accordance with other studies, we found proof for the statements that the motivation of judicial clients towards change in general and treatment for several problems more in particular is low and primarily extrinsic (Anglin & Hser, 1991; Anglin, Prendergast, & Farabee, 1998; Brochu, Guyon, & Desjardins, 1999; De Leon, Melnick, Thomas, Kressel, & Wexler, 2000). Although this is certainly true for the incarcerated offenders, the participating released detainees displayed a higher motivation to change compared to their incarcerated counterparts. On

basis of the statements expressed by the incarcerated and recently released offenders as well as by the treatment staff members, judicial reasons, such as probation and conditional release, could be identified as the most important ones in order to follow treatment. This underscores the importance of mandated or coerced treatment, which effectiveness has been demonstrated by several researchers (Farabee, Prendergast, & Anglin, 1998; Fischer, Rehm, Uchtenhagen, & Kirst, 2002; Hall, 1997). Besides this extrinsic motivation, each group indicates the importance of intrinsic motivation as well, primarily from the idea that you have to stand behind and take up responsibility within your own process of change.

This study has several limitations, which impede the generalization of our findings: the relatively small number of participants, the potential bias because of using only participants willing to take part in the study instead of a randomized sample and the fact that the population of offenders comprised only one woman, which may have led to a more 'male' view on problems. Therefore, the research should be replicated on a larger scale in order to find out whether or not the results can be generalized. Although the presented results are intriguing, the small sample size means that these findings may not replicate well with a larger data set. Therefore, this chapter should be considered as an exploratory study, aiming to stimulate further research.

7.5. CONCLUSION

In relation to the research questions addressed in our study concerning (1) the most common problem areas and associated treatment needs; (2) the importance of prison-based treatment and; (3) the motivation of offenders towards treatment and (4) differences between the three participant groups, the results suggest that there is a not to be underestimated difference in opinion between offenders and service providers with regard to the identification of the most important problems inside as well as outside correctional establishments. This finding pleads for the necessity to carefully assess the support expectancies of both incarcerated and released offenders, taking the unique needs of each individual into account. As the results suggest that released offenders seem to struggle even more with problems concerning psychological status as compared to incarcerated offenders, the need for continuous through- and after-care is apparent. The provision of prison-based treatment is considered as quintessential by both the offender population and the service providers, who participated in

this study. Preparing the detainee for the return to society in this respect can be regarded at as the first step within a treatment and support continuum for offenders (cf. Butzin et al., 2002). Motivating offenders to take part in prison-based treatment initiatives and the associated aftercare is an important challenge for the criminal justice system, which can be accomplished by cooperation and partnerships between correctional establishments and community-based treatment providers (Nurse, Woodcock, & Ormsby, 2003).

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Table 7.5.: Expressions per coding category for 'released offenders' (percentages are within number of expressions per coding category)

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Problems (n=143)				
Physical health	1	0.7	1	0.7
Education / employment	7	4.9	15	10.5
Alcohol / substance use	9	6.3	11	7.7
Legal status	18	12.6	1	0.7
Family / social relations	11	7.7	13	9.1
Psychological status	17	11.9	14	9.8
Other	4	2.8	17	11.9
No problems	2	1.4	1	0.7
General	0	0.0	1	0.7
Total	**69**	**48.3**	**74**	**51.7**

	Positive		Negative	
	n	**%**	**n**	**%**
Importance prison-based treatment (n= 35)				
Physical health	2	5.7	0	0.0
Education / employment	1	2.9	0	0.0
Alcohol / substance use	4	11.4	0	0.0
Legal status	8	22.9	0	0.0
Family / social relations	1	2.9	0	0.0
Psychological status	4	11.4	0	0.0
Other	1	2.9	0	0.0
General	10	28.6	4	11.4
Total	**31**	**88.6**	**4**	**11.4**
Remaining category	*Reality (n=9)*			

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Treatment needs (n=55)				
Physical health	0	0.0	0	0.0
Education / employment	1	1.8	3	5.5
Alcohol / substance use	2	3.6	2	3.6
Legal status	3	5.5	0	0.0
Family / social relations	0	0.0	0	0.0
Psychological status	4	7.3	3	5.5
Other	1	1.8	6	10.9
No	11	20.0	2	3.6
General	5	9.1	3	5.5
Needs realized	0	0.0	3	5.5
Needs not realized	4	7.3	2	3.6
Total	**31**	**56.4**	**24**	**43.6**

	Extrinsic		Intrinsic	
	n	**%**	**n**	**%**
Motivation n=43)				
Physical health	0	0.0	0	0.0
Education / employment	1	2.3	1	2.3
Alcohol / substance use	0	0.0	2	4.7
Legal status	15	34.9	1	2.3
Family / social relations	2	4.7	0	0.0
Psychological status	0	0.0	4	9.3
Other	0	0.0	7	16.3
General	0	0.0	10	23.3
Total	**18**	**41.9**	**25**	**58.1**
Remaining categories	*No motivation (n= 1)*			

Table 7.6.: Expressions per coding category for 'incarcerated offenders' (percentages are within number of expressions per coding category)

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Problems (n=127)				
Physical health	1	0.8	0	0.0
Education / employment	1	0.8	5	3.9
Alcohol / substance use	7	5.5	6	4.7
Legal status	39	30.7	3	2.4
Family / social relations	18	14.2	6	4.7
Psychological status	9	7.1	3	2.4
Other	10	7.9	3	2.4
No problems	8	6.3	7	5.5
General	1	0.8	0	0.0
Total	**94**	**74.0**	**33**	**26.0**

	Positive		Negative	
	n	**%**	**n**	**%**
Importance prison-based treatment (n= 41)				
Physical health	2	4.9	0	0.0
Education / employment	0	0.0	0	0.0
Alcohol / substance use	3	7.3	0	0.0
Legal status	7	17.1	0	0.0
Family / social relations	5	12.2	0	0.0
Psychological status	2	4.9	0	0.0
Other	5	12.2	0	0.0
General	13	31.7	4	9.8
Total	**37**	**90.2**	**4**	**9.8**
Remaining category	*Reality (n=24)*			

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Treatment needs (n=68)				
Physical health	0	0.0	0	0.0
Education / employment	0	0.0	4	5.9
Alcohol / substance use	5	7.4	2	2.9
Legal status	6	8.8	0	0.0
Family / social relations	5	7.4	3	4.4
Psychological status	4	5.9	1	1.5
Other	3	4.4	4	5.9
No	14	20.6	10	14.7
General	1	1.5	0	0.0
Needs realized	1	1.5	1	1.5
Needs not realized	2	2.9	2	2.9
Total	**41**	**60.3**	**27**	**39.7**

	Extrinsic		Intrinsic	
	n	**%**	**n**	**%**
Motivation (n=37)				
Physical health	0	0.0	0	0.0
Education / employment	0	0.0	0	0.0
Alcohol / substance use	0	0.0	2	5.4
Legal status	13	35.1	0	0.0
Family / social relations	7	18.9	2	5.4
Psychological status	0	0.0	0	0.0
Other	0	0.0	1	2.7
General	0	0.0	12	32.4
Total	**20**	**54.1**	**17**	**45.9**
Remaining categories	*No motivation and motivation (n=2)*			

Table 7.7.: Expressions per coding category for 'treatment staff'(percentages are within number of expressions per coding category)

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Problems (n=206)				
Physical health	3	1.5	2	1.0
Education / employment	11	5.3	35	17.0
Alcohol / substance use	5	2.4	4	1.9
Legal status	8	3.9	12	5.8
Family / social relations	13	6.3	26	12.6
Psychological status	13	6.3	20	9.7
Other	13	6.3	39	18.9
No problems	0	0.0	0	0.0
General	1	0.5	1	0.5
Total	**67**	**32.5**	**139**	**67.5**

	Positive		Negative	
	n	**%**	**n**	**%**
Importance prison-based treatment (n= 51)				
Physical health	0	0.0	0	0.0
Education / employment	1	2.0	0	0.0
Alcohol / substance use	1	2.0	0	0.0
Legal status	9	17.6	0	0.0
Family / social relations	6	11.8	0	0.0
Psychological status	5	9.8	0	0.0
Other	25	49.0	0	0.0
General	4	7.8	0	0.0
Total	**51**	**100.0**	**0**	**0.0**
Remaining category	*Reality (n=22)*			

	Inside prison		Outside prison	
	n	**%**	**n**	**%**
Treatment needs (n=0)				
Physical health	n/a	n/a	n/a	n/a
Education / employment	n/a	n/a	n/a	n/a
Alcohol / substance use	n/a	n/a	n/a	n/a
Legal status	n/a	n/a	n/a	n/a
Family / social relations	n/a	n/a	n/a	n/a
Psychological status	n/a	n/a	n/a	n/a
Other	n/a	n/a	n/a	n/a
No	n/a	n/a	n/a	n/a
General	n/a	n/a	n/a	n/a
Needs realized	n/a	n/a	n/a	n/a
Needs not realized	n/a	n/a	n/a	n/a
Total	n/a	n/a	n/a	n/a

	Extrinsic		Intrinsic	
	n	**%**	**n**	**%**
Motivation (n=60)				
Physical health	0	0.0	0	0.0
Education / employment	0	0.0	0	0.0
Alcohol / substance use	0	0.0	1	1.7
Legal status	32	53.3	0	0.0
Family / social relations	2	3.3	0	0.0
Psychological status	0	0.0	0	0.0
Other	2	3.3	5	8.3
General	3	5.0	15	25.0
Total	**39**	**65.0**	**21**	**35.0**
Remaining categories	*No motivation and motivation (n=5)*			

8

General Discussion

The following paragraphs aim to integrate the most important findings of this dissertation. Based on a concise summary of the main results, obtained by the separate studies, the general conclusions of the dissertation are discussed. In the ensuing section, we address potential implications for daily practice. Finally, limitations of the study are inventoried, leading to suggestions for future research.

8.1 INTRODUCTION

This dissertation aimed at mapping quintessential (treatment-related) characteristics, particularly focusing on motivation to change and readiness towards treatment in prison-based therapeutic communities and other treatment modalities, in a sample of incarcerated drug-involved criminal offenders. Specific attention has been given to differences between participants with and their counterparts without special intellectual needs. More into detail, the following three objectives were premised. First of all, we aimed to explore the development, evolution and current tendencies in prison-based therapeutic communities. Secondly, we wanted to assess the characteristics of drug-involved criminal offenders, focusing primarily on substance abuse severity, intellectual abilities and ethnical and cultural background. A related goal consisted of looking into the differences within diverse life areas between participants with and without special intellectual needs. Finally, we wanted to investigate more closely the complex relationship between intellectual abilities and motivational indices in drug-involved offenders and potential distinctions concerning motivation and readiness between participants with low, moderate and high intellectual abilities. In order to achieve these objectives, six separate studies were executed.

A literature study was carried out to investigate the current tendencies in correction-based substance abuse treatment, more particularly in therapeutic communities (TC) (*chapter 2*); whilst an empirical study further looked into the main method used in TCs: the confrontational encounter (*chapter 3*). Two studies tackled - for this dissertation - relevant issues (definition and assessment, treatment needs and client characteristics) with regard to specific target groups, i.e. people with intellectual disabilities (*chapter 4*) and ethnically diverse persons (*chapter 5*). A pilot study investigated the motivation of incarcerated criminal offenders with and without special intellectual needs (*chapter 6*), which was further elaborated by a study on the perception of treatment needs and motivation, in a sample of incarcerated offenders, recently released offenders and treatment staff (*chapter 7*).

These studies were based on quantitative (*chapters 4* and *6*) and qualitative (*chapter 5*) research methodologies or a combination of both (*chapters 3* and *7*). The difference between the quantitative and qualitative studies primarily related to the applied data collection method (e.g. standardized test vs. in-depth interview) and the performed main analysis technique (e.g. a multivariate analysis of variance using SPSS vs. a second order hermeneutic unit coding process by means of WinMAX).

The following paragraphs summarize the main findings of the dissertation, which are generally discussed. Finally, we address implications for practice, limitations of the study and propositions for future research.

8.2. GENERAL DISCUSSION OF THE MAIN RESULTS

8.2.1. THE DEVELOPMENT, EVOLUTION AND CURRENT TENDENCIES IN PRISON-BASED THERAPEUTIC COMMUNITIES

- CURRENT TENDENCIES IN PRISON-BASED THERAPEUTIC COMMUNITIES

Although many studies underscored the effectiveness of prison-based TCs (Cullen, 1997; Hiller, Knight, Devereux, & Hathcoat, 1996; Lang & Belenko, 2000; Swartz, Lurigio, & Slomka, 1996; Wexler, De Leon, Thomson, Kressel, & Peters, 1999), little research dealt with the historical development, current application and future trends of the in-prison therapeutic community (Rawlings, 1999). There has been limited scientific attention as well for the comparison of the different (prison-based) treatment modalities, coined with the same term: the hierarchical concept-based TC and the democratic milieu-oriented TC (Lipton, 1998). By means of a comprehensive comparative historical review, based on published and gray literature findings, we traced back the historical development of the 'two' TC-branches. We found that instead of being regarded at as opposite, both types of therapeutic communities should be considered as complementary, each targeting a different end of the treatment continuum. Whilst concept-based TCs are more behaviorally-oriented in nature, Maxwell Jones-type TCs are more influenced by psychoanalytical roots, targeting a further social maturation (cf. *chapter 2*).

- EVOLUTION OF THE ENCOUNTER GROUP IN (PRISON-BASED) TCS FROM HARSH CONFRONTATION TOWARDS MORE DIALOGUE

Clinical observations, some literature findings and the results of our study presented in *chapter 2*, showed that the encounter group method evolved from harsh confrontation, similar to the nature of its predecessor *the Game* in Synanon, towards a more respectful and balanced dialogue (Bracke, 1996; De Leon, 2000; Poulopoulos, 1995). Yet, up until now, these observations were never empirically

underpinned. In order to achieve this objective, we performed a case study in one therapeutic community, using taped encounter proceedings with a time-interval of 20 years, which were analyzed and compared. The research methodology goes back to the construction of 'ideal types' (Max Weber) (Colins, Broekaert, Vandevelde, & Van Hove, submitted), which enabled us to execute a second-order coding process and a consequent quantification of the qualitative material (Kuckartz, 1998). The findings underscored the reported clinical observations. Therefore, we concluded that the encounter group, although still a confrontational method, evolved from a harsh 'arena' of confrontation towards a more respectful dialogue, in which real emotions – even the negative ones – are freely disclosed (cf. *chapter 3*). This evolution should be situated within the global maturation of the 'new' therapeutic community (cf. *chapter 2*) (Broekaert, Kooyman, & Ottenberg, 1998).

8.2.2. THE ASSESSMENT OF SUBSTANCE ABUSE SEVERITY AND INTELLECTUAL DISABILITIES IN DRUG-INVOLVED OFFENDERS.

- ASSESSING INTELLECTUAL DISABILITIES IN DRUG-INVOLVED CRIMINAL OFFENDERS

As we aimed at mapping client characteristics in the specific target group of incarcerated criminal offenders with special intellectual needs, a clear definition of intellectual disabilities proved to be indispensable (American Association on Mental Retardation (AAMR), 2002; Holland, Clare, & Mukhopadhyay, 2002; McBrien, 2003). Based on our findings presented in *chapter 4*, current health and care paradigms from different disciplines, i.e. disability research and studies within the addictions field, could potentially influence the definition and assessment of intellectual disabilities in drug-involved criminal offenders. Assessment instruments from substance abuse research (European version of the Addiction Severity Index) (Hendriks, Kaplan, van Limbeek, & Geerlings, 1989) and disability research (Raven's Standard Progressive Matrices) (Raven, Court, & Raven, 1988) were integrated, each providing additional information to broaden the view on clients with special intellectual needs. The findings specifically indicated the importance of taking context-oriented variables into account when defining intellectual disability and contra-indicated the use of a single criterion to decide whether or not someone could be labeled as 'intellectually disabled'. Based on these findings, we have pled for a multi-dimensional assessment of intellectual disabilities throughout this dissertation.

This is further supported by our results presented in *chapters 5, 6* and *7*, in which the careful assessment of client characteristics and support needs is advocated from multiple perspectives. Besides attention for intellectual disabilities, the focus is also directed at other attributes, such as ethnical and cultural origin, individual support expectancies, substance abuse severity and psychological health.

- CHARACTERISTICS OF DRUG-INVOLVED OFFENDERS WITH SPECIAL INTELLECTUAL NEEDS

The results of the pilot study presented in *chapter 4* indicated that almost half of the participating incarcerated drug-involved offenders score definitely below average on the Raven's Standard Progressive Matrices (SPM). In addition, about 15% of the total group could be considered as 'intellectually impaired' on basis of the reported SPM-figures (score at or below the fifth percentile).

A great part of the total sample of incarcerated drug-involved offenders struggled with moderate to serious problems in diverse life areas, including substance abuse, legal, and psychiatric difficulties. Furthermore, the majority of the participants (had) experienced health problems, both physical and psychological; long histories of substance abuse; difficulties with social network members; an insecure financial situation and outspoken trajectories of criminal activity and related convictions. When considered more into detail, the differences between people with and without special intellectual needs were rather limited, except for psychological problems. Not surprisingly, people labeled as intellectually disabled, experienced more difficulties to understand (complex) questions and tasks (cf. Fals-Stewart & Schafer, 1992). Finally, we found that only a small proportion of the latter group reported to have a job when incarcerated and earn money.

The pilot results of our study described in *chapter 6* further underscored these findings: legal difficulties, substance abuse and psychological problems were identified as the most severe problem areas for the total group. When looking into differences between offenders with high, average and low intellectual abilities, the following results were noted. Highly intelligent offenders experienced less drug and judicial problems as compared to their counterparts with average intellectual abilities. The participants with low intellectual abilities displayed significantly more problems related to psychological health and difficulties with social network members in comparison to the highly intelligent offenders. In conclusion, although the differences are rather limited, drug-involved criminal offenders with special intellectual needs seemed to come across the most serious, especially

psychological, problems in comparison to their counterparts without these special needs.

- CULTURAL RESPONSIVENESS IN SUBSTANCE ABUSE TREATMENT

Ethnical and/or cultural origin is considered as an important variable when assessing a wide variety of client characteristics, including intellectual abilities (Ho, 1996), issues related to criminal offending, for instance inequality in legal procedures (Crutchfield, Bridges, & Pitchford, 1994) and substance abuse (Finn, 1994, 1996). Therefore, we acknowledged the necessity of taking ethno-cultural factors into account within this dissertation (cf. *chapter 5*).

The participating professionals and clients stressed the importance of not organizing specific and separate treatment for ethnical minority clients, as this would isolate them from other autochthon clients. Instead, they suggested using one or more adapted methods, taking the specific needs of minority clients into account. This result advocates the importance of continuous through- and after-care, in accordance with our findings presented in *chapter 7*. Case management, aiming at improving co-ordination and continuity of care (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002), as well as integrated treatment systems (Broekaert & Vanderplasschen, 2003) seem to offer promising insights within this respect. Especially, outreaching activities, which are an essential part of case management, could be used in order to actively involve clients with special needs, particularly those with another ethnical and cultural background. Moreover, the development of a network in which both substance abuse treatment providers as well as services which specifically tackle problems related to ethnical diversity are represented, seems to offer important prospects.

8.2.3. MOTIVATION AND TREATMENT NEEDS OF INCARCERATED DRUG-INVOLVED OFFENDERS.

- MOTIVATION AND READINESS TOWARDS TREATMENT IN THERAPEUTIC COMMUNITIES AND OTHER TREATMENT MODALITIES

Motivation and readiness are recognized as quintessential variables in the field of substance abuse treatment for offenders without special intellectual needs (De Leon, Melnick, Thomas, Kressel, & Wexler, 2000; Hiller, Knight, Leukefeld,

& Simpson, 2002; Melnick, De Leon, Thomas, Kressel, & Wexler, 2001). Although the theoretical models, underlying these motivational concepts, for a great part rest upon cognitive abilities, only a limited number of studies have investigated the relation between motivational attributes and intellectual abilities (DiClemente, 1999), especially in criminal justice populations (Mendel & Hipkins, 2002). Therefore, we aimed at mapping client characteristics, focusing on intellectual abilities and motivation towards treatment in a population of non-treatment drug-involved incarcerated offenders (cf. *chapter 6*). The pilot results showed that drug-involved criminal offenders in general display low to moderate motivation and readiness to enter substance abuse treatment. This is supported by our qualitative findings, presented in *chapter 7*, as we found proof for the statements that the motivation of judicial clients towards change in general and treatment for several problems more in particular is low and primarily extrinsic. These results are in accordance with other international studies targeting criminal justice populations (Anglin & Hser, 1991; Anglin, Prendergast, & Farabee, 1998; Brochu, Guyon, & Desjardins, 1999; De Leon, Melnick, Thomas et al., 2000).
Based on our study presented in *chapter 7*, the reported findings concerning the low levels of motivation in this dissertation, seem particularly true for incarcerated offenders, as the participating released detainees displayed a higher motivation to change compared to their incarcerated counterparts. Yet, the main incentives to start or maintain ongoing treatment are identical for both groups, as the incarcerated and recently released offenders mostly talked about judicial reasons, such as probation and conditional release. In line with previous research, this underscores the importance of coerced treatment (Vandevelde & Vanderplasschen, 2003; Wild et al., 2001).

Furthermore, we found that intelligence has a significant effect on motivation within our sample of drug-involved offenders, unlike other variables such as length of prison sentence and number of violent crimes, for which no correlations were found with motivational indices (*chapter 6*). Participants with high intellectual abilities are less motivated to enter and stay in substance abuse treatment, compared to their counterparts with average and low intellectual abilities. Because motivational attributes are able to predict engagement and retention in community-based treatment (De Leon, Melnick, Kressel, & Jainchill, 1994; Joe, Simpson, & Broome, 1999) and substance abuse treatment in criminal justice settings (Hiller et al., 2002; Sia, Dansereau, & Czuchry, 2000), which is – in turn – related to treatment effectiveness, this is an important result. These findings offer – albeit limited – empirical proof for the hypothesis that intellectual deficits might be responsible for the misinterpretation of motivational levels in substance

abusers with low intellectual abilities. There is indeed a great risk that treatment staff members misunderstand problems related to information-processing activities as low motivation. Since our results suggest that people with low and average intellectual abilities are more motivated than those clients with high intellectual abilities are, special attention should be paid to assess intellectual abilities and to make sure that treatment demands are well understood by all clients. This finding underscores our statement, presented in *chapter 4*, that clients with special intellectual needs do not always fully understand – the sometimes complex – treatment demands.

- TREATMENT NEEDS OF DRUG-INVOLVED INCARCERATED OFFENDERS

Because of the growing prison populations worldwide and the demonstrated effects of evidence-based treatment interventions (Allen, MacKenzie, & Hickman, 2001; Dowden, Antonowicz, & Andrews, 2003), rehabilitation efforts gained influence after years of little interest. An inventory of treatment needs of incarcerated drug-involved offenders seemed important, especially since motivation and treatment needs are closely related (Rapp, Li, Siegal, & DeLiberty, 2003). The most common problems mentioned by the incarcerated and recently released offenders primarily address psychological difficulties and problems associated with judicial issues, the social network and family relations (cf. *chapter 7*). For the greater part, these qualitative results are in accordance with our quantitative findings reported in *chapters 4* and *6*. When the qualitative results are looked upon more closely, the nature of problems incarcerated and recently released offenders talked most about, differed according to the specific period targeted (during incarceration vs. recently released). In general, both groups of participating offenders identified judicial issues and problems related to social relationships amongst the most stringent difficulties when incarcerated. Once released, other problems prevailed, with differences between the research groups. According to many incarcerated offenders, especially problems related to judicial issues (such as probation conditions) and alcohol and substance use will be most important, although a substantial proportion indicated that no problems will rise, once released. The research group of recently released offenders primarily demonstrated pragmatic problems, for instance associated with housing and employment, besides psychological difficulties.

Furthermore, an important finding, based on the EuropASI-severity scores, pointed out that incarcerated offenders experience less problems as compared to

with recently released offenders. This distinction is most prevalent for psychological problems. As outlined in *chapter 6*, we found proof for the statements that the motivation of judicial clients towards change in general and treatment for several problems more in particular is low and primarily extrinsic. Moreover, the participants indicated the importance of prison-based treatment, although a relative elevated proportion of statements showed that incarcerated offenders have no in-prison treatment needs. In conclusion, the results suggest that released offenders seem to experience more problems concerning substance abuse and psychological status as compared to incarcerated offenders, which advocates the need for continuous through- and aftercare. Therefore, preparing inmates for the return to society can be considered as a first step within a treatment and support continuum for offenders (cf. Butzin, Martin, & Inciardi, 2002 and *chapter7*).

8.3. IMPLICATIONS FOR PRACTICE

This study aimed at investigating important treatment-related attributes of incarcerated drug-involved offenders. Because this specific target group constitutes a substantial proportion of the current population in therapeutic communities and other treatment modalities, both inside and outside the judicial system, collaboration between scientists and practitioners is quintessential in order to meet the specific (treatment) needs of those clients.

The discussion about whether or not it is preferable to organize treatment inside correctional establishments, is relevant. The current policy of tackling drug problems has shifted from merely repression to more rehabilitating practices in several European countries. This evolution is particularly embodied within the development of extra-judicial measures, by which court sentences, often resulting in imprisonment, could be avoided. Besides an ethical rationale, i.e. the fact that treatment could be considered as more suitable than incarceration for people who experience serious difficulties, economical and recent scientific insights underpin these policies. Treatment is less expensive and more effective than a prison sentence with regard to reducing substance use and involvement in criminal activities. Moreover, it could be an important step towards diminishing the over-population in many correctional establishments (cf. *chapter 1*).

With regard to the application of prison-based TCs and the place of the encounter group herein, especially the more '*humane*' nature of the current encounter group

method could have important implications, particularly for the vulnerable participants targeted in this dissertation. When encounter groups are organized as confrontational and harsh as its historical predecessors, the danger of breaking the clients' personality, instead of the image after which they are hiding, is not inconceivable (Bracke, 1996). This seems particularly true for people with special intellectual needs, who often struggle with communication skills (cf. *chapter 4*). Since exactly these communicative competences are essential tools in the encounter, individuals with low intellectual abilities could experience serious disadvantages compared to their (highly) intelligent counterparts. Therefore, a more equal dialogue, with respect for each participant's identity and needs, could create an atmosphere of trust and confidence, enabling people with special intellectual needs to disclose personal feelings. As treatment systems have further developed, we notice a more advanced selection and matching of the target population towards adapted approaches. An inherent danger of assessing motivation, often based on clinical observations, is the potential pre-selection of individuals who seem more open to change in the first place (cf. *chapter 6*). This could impede the selection of clients with low intellectual abilities, for whom the encounter group, especially in its historical shape, seemed not suitable.

Comparable to other research (De Leon, Melnick, Thomas et al., 2000; Sia et al., 2000), the study clearly indicated low to moderate levels of motivation towards change in general and readiness towards substance abuse treatment more in particular. The available places in prison-based treatment services are rather limited in Belgian corrections, which may have led to the particularly low motivation figures presented in this dissertation. Therefore, the provision of short-term concrete treatment opportunities could potentially increase motivation. Alternative extra-judicial measures, including probation and conditional release, could prevent long-term prison sentences for substance abusers, and providing them with useful treatment opportunities. As cooperation between the criminal justice system and substance abuse treatment facilities is essential, especially with regard to different forms of coerced (community-based) treatment, a clear framework, with respect for the identity of each partner, is definitely needed (Van Cauwenberghe, 2002). Although the criminal offenders might be only extrinsically motivated from the onset of coerced treatment, an evolution towards a more intrinsically based motivation is possible (cf. Anglin & Hser, 1991). Hence, treatment services should specifically tackle motivational indices at the start of a treatment episode, as is already a common procedure in many – if not all – treatment facilities.

A noteworthy finding is that participants with high intellectual abilities are less motivated to enter and stay in substance abuse treatment, compared to their counterparts with average and low intellectual abilities. To a certain extent, this result supports other research, which has demonstrated that intellectual deficits might be responsible for the confusion of motivational levels in substance abusers with low intellectual abilities. As a pilot study already proved that motivational enhancement strategies might work for people with intellectual disabilities if their special needs are addressed (Mendel & Hipkins, 2002), this finding underscores the necessity to carefully assess intellectual functioning, besides other characteristics, in drug-involved criminal offenders. Although this may seem a time- and resources-consuming procedure, our research on the possible integration of health and care paradigms in substance abuse treatment and disability research, described in *chapter 4*, clearly shows how several self-contained assessment strategies and instruments, which are often already implemented to some degree, could be integrated. This entails the enlargement of information about cognitive abilities (usually IQ-scores obtained by standardized tests) with qualitative in-depth data about other important context-related life domains, including adaptive behavior (AAMR, 2002). Since the latter data are difficult to obtain, especially within correctional settings, *chapter 4* proposes a possible procedure to collect information by means of instruments from allied disciplines, such as substance abuse research. As a consequence, the motivational enhancement strategies at the beginning of a treatment episode, mentioned in the previous paragraph, should be specifically tailored towards the special needs of the clients.

One of the most applied motivation enhancement techniques in this respect is the client-centered *motivational interviewing* method, based on Prochaska & DiClemente's stages of change. It aims at stimulating intrinsic motivation by supporting clients to evaluate the pros and cons associated with behavior change (Miller & Rollnick, 2002). As studies have illustrated that as little as one motivational interviewing session can lead to a significant positive change (Brown & Miller, 1993), its implementation could have far-reaching consequences, especially for clients with special needs, such as criminal offenders. Mendel & Hipkins (2002) demonstrated the usefulness of motivational interviewing for forensic clients with intellectual disabilities, if the sessions were tailored towards the needs of this specific target group. Besides being focused on a small number of carefully selected members, these sessions were interactive, making use of exercises and visual aids. Mendel and Hipkins (2002, p.156) state that 'examples were used, such as case vignettes, involving popular media personalities', and that

exercises included 'the use of stickers on a visual pair of scales to illustrate weighing up the good and bad things about drinking alcohol as generated by the group'. In this respect, node-link mapping could be regarded an important graphic representation tool, which could enhance the effectiveness of suchlike group counseling sessions (Pitre, Dansereau, Newbern, & Simpson, 1998). This technique visually maps feelings and ideas in boxes, which are connected by lines. Research, primarily in samples of (forensic) substance abusers, demonstrated that node-link mapping is particularly effective for specific target groups, including less educated clients and persons with attentional and communicative difficulties.

Furthermore, motivating offenders to participate in (prison-based) treatment initiatives and the associated aftercare is an important challenge for the criminal justice system, which can be accomplished by cooperation and partnerships between correctional establishments as well as other criminal justice services and community-based treatment providers (Nurse, Woodcock, & Ormsby, 2003). Within this respect, networking activities – aiming at exchanges of expertise – between services for people with intellectual disabilities, substance abuse treatment services and centers for integration and support to ethnic minorities, for instance on selected 'difficult cases', could be interesting.

Finally, this dissertation clarifies the importance of not segregating clients with special needs, but on the other hand integrating adapted methodologies within the existing treatment plans in order to take specific needs into account. Using evidence-based research findings about treatment needs, client characteristics, treatment outcomes, amongst other issues, are primordial within this respect, in order not to get bogged down in a politically correct discourse of 'integration' and 'inclusion', without undertaking action. As our research pointed out that there might be differences in perception between clients and treatment staff members regarding the identification of the most important problems related to incarceration (*chapter 7*) and cultural responsiveness (*chapter 5*), a close respectful collaboration with the clients, who should be recognized as the main actors within their own treatment process, seems *a condition sine qua non* for effective treatment.

8.4. LIMITATIONS OF THE STUDY

Although the methodological limitations have already been discussed into detail for each separate study, this section specifically aims at giving an integrated

overview of the limitations of the dissertation as a whole, leading to a concise overview of potential suggestions for further research.

First of all, this dissertation comprises of six self-contained separate studies, each representing a chapter: a historical comparative literature review, a case study, two qualitative and two quantitative studies. The studies' diverse objectives and used methodologies may have hampered the construction of a self-explaining, straightforward structure within this dissertation. We have addressed this shortcoming by supplying a substantial introductory and concluding chapter, in which the mutual coherence of the chapters is elaborated, clearly identifying the underlying common rationale of each study.

Secondly, a generalization of the reported pilot findings is extremely difficult primarily because of the relatively small numbers of participants overall and the fact that it was not possible to use randomized samples in any of the six studies. Moreover, the data-analysis took place in a limited number of services, e.g. one therapeutic community (*chapter 3*) and four correctional establishments (*chapters 4* and *6*), which further impeded the transfer of the presented findings to larger client populations.

Thirdly, a potential bias in selecting the participants could have occurred, especially with regard to the studies described in *chapters 4* and *6*, as the criminal offenders themselves could decide whether or not to take part in the study. Using an informed consent procedure, refusal rates of up to 40% were noticed. As we have no information about the characteristics of those offenders who refused to take part in the study, nor about their incentives not to participate, the presented figures should be interpreted with caution. As we could potentially assume that highly intelligent offenders will be more suspicious towards cooperation in a study, tackling delicate topics, such as in-prison illegal substance use, we may have over-reported the prevalence of intellectual disabilities in drug-involved offender populations. Furthermore, there is a not to be underestimated risk that only people who already displayed some motivation to change participated in the study, which may have led to an over-estimation of the used motivational indices. Again, we have no information about the non-participating offenders, which impedes further investigation within our own study samples.

A related fourth limitation is the reliance on self-reported data, which could have led to an over- or under-estimation of important variables within this dissertation, such as in-prison substance abuse. Moreover, difficulties in understanding could

potentially have led to socially desirable answering trends and conforming oneself to what is expected, especially in the group of clients with special intellectual needs. We tried to overcome these shortcomings by clarifying and/or changing the order of the questions; double-checking the gathered data, e.g. by summarizing the life story of the participants; comparing it with the information provided and confronting the client with potential differences. Moreover, when possible, we tried to obtain information using different data sources, including personal interviews, the administration of standardized instruments and data based on the client files of the Prison's Psycho-Social Service (*data-triangulation*).

Fifthly, although we plead for a multi-dimensional assessment of intellectual disabilities within offender populations – based on current care paradigms underscoring the importance of contextual variables – we chose to assign participants to the research groups (people with and without intellectual disabilities, cf. *chapter 4* and participants with low, moderate and high intellectual abilities, cf. *chapter 6*) on basis of one instrument (Raven's SPM). This choice was based on pragmatic reasons, as well as the fact that IQ-scores are already widely used in correctional establishments. Moreover, we enlarged this assessment procedure by integrating findings obtained by other instruments from allied disciplines, i.c. substance abuse (treatment) research. (cf. *chapter 4*).

A sixth limitation is the lack of a procedure to formally check socially desirable answering trends. As the study tackled delicate topics, such as in-prison substance abuse, and the commitment of other illegal activities while incarcerated, which could potentially aggravate a detainees' judicial status, socially desirable answers could not be excluded. Yet, in order to address this limitation, we fully explained that all the information disclosed to us was handled confidentially, that no personal information was passed to anyone else and that the provided data would not be used against or in favor of ongoing cases.

8.5. FUTURE RESEARCH

This dissertation, focusing on the specific target group of drug-involved offenders (with special intellectual needs), learned us that motivation of criminal offenders, incarcerated in Flemish prisons, is generally low, and mostly extrinsic. Moreover, we found that motivation is partially influenced by intellectual abilities. Given the primarily descriptive nature of the study, as we did not implement any (modification of existing) treatment initiatives or suchlike experimental conditions,

but merely described the existing situation in Flemish correctional establishments, it would be worthwhile to investigate the following topics in future research.

Because research pointed out that motivational indices could successfully predict retention (e.g. De Leon, Melnick, & Hawke, 2000), which – in turn – could be considered as indicators of treatment effectiveness and due to the reported prevalence of intellectual disabilities within drug-involved offenders (cf. *chapter 4*), more longitudinal outcome research should be carried out for this specific target group of criminal offenders, identifying changes in motivation over time. As our study did only assess client characteristics within a limited sample of non-treatment drug-involved offenders, further investigation in larger - if possible – randomized samples is definitely necessary.

A related proposition for further research deals with the identification of the most applicable type of treatment for incarcerated substance abusers with special needs. This seems especially relevant in times of client matching, as commentators pointed out that still many questions remain about offering the most optimal treatment to every unique client (Rehm, 2002). As research already identified differences between offenders and/or substance abusers with and without special intellectual needs (Glaser & Deane, 1999; Holland et al., 2002; Lindsay, 2002; McGillivray & Moore, 2001), which was supported by our findings (cf. *chapter 4* and *6*), a careful assessment of which treatment modalities are most suitable is certainly worthwhile.

This brings us to a third proposal: the assessment and consequent implementation of potential modifications (e.g. the implementation of node-link mapping) to existing treatment modalities in order to take specific support needs into account, as we demonstrated for (incarcerated) offenders (cf. *chapter 7*) and clients with another ethnical and cultural background, concerning the concept of cultural responsiveness (cf. *chapter 5*). More empirical studies, incorporating the views of the target group itself, are particularly necessary. This could be accomplished by cooperative and/or qualitative research, using first-hand witnesses and 'hands-on' experts.

Fourthly, the most important variables tackled in this dissertation, i.c. (the complex relation between) substance abuse, motivation and intellectual abilities, were investigated within a drug-involved incarcerated offending population. An alternative pathway could be followed if these attributes were studied within samples of people with intellectual disabilities. Other research already indicated

that substance abuse in people with special intellectual needs is an overlooked problem (Christian & Poling, 1997), especially within the criminal justice field (McGillivray & Moore, 2001).

Finally, it would be interesting to question whether or not motivation is also influenced by intellectual abilities within other specific target groups, for whom applications of the transtheoretical model are developed, such as obese children and adults, people struggling with anger management and diabetes patients. Specific attention for the implementation and evaluation of motivational enhancement techniques, adapted to the special intellectual needs of sub-populations within these target groups, could likely contribute important information. Comparable to the aforementioned suggestions (cf. 8.3.) to tailor interventions on the intellectual needs of substance abusing clients, interactive sessions using visual cues, exercises, and relevant techniques, such as node-link mapping seem to offer promising prospects. Most importantly, potential similarities may become clear, which could stimulate joint cooperation between allied disciplines, such as substance abuse treatment professionals, health care experts and service providers within the disability field.

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