EVALUATION OF PROGRAMS FOR DRUG USERS
IN PRISON

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That a substantial proportion of prisoners have drug (including alcohol) problems has been established. What is less certain is what can be done for drug users while they are in prison. In this paper I had hoped to be able to describe what sorts of programs should be run for drug users in prison, based on the results of the evaluations which have been conducted. Unfortunately evaluations of programs for drug users in prison are rare. Numerous programs have been described. The performance of participants has been documented for some programs. However studies which allow us to assess whether prison-based treatment really makes a difference, are very difficult to find. Because there are so few evaluations, it is of interest to determine what gets in the way of conducting informative evaluations.

In my paper, I shall address the following four questions:

i.) what sorts of approaches to programs for drug users in prison have been tried?
ii.) how can we measure program success?
iii.) what are the obstacles to an informative evaluation of programs for drug users in prison?
iv.) what are the main lessons to be learnt from the work done so far?

1. Overview of the approaches tried

In a paper such as this, it is not possible to describe in detail all of the programs which have been documented in the literature. Hence I shall commence by providing a broad overview of the types of approaches tried in prison.

There have been three broad approaches taken:

i.) it is futile to attempt to treat imprisoned drug addicts;

ii.) drug users in prison should have access to programs available to drug users in the community;

iii.) special programs should be conducted for drug users in the prison.

I shall discuss the rationales for each of these approaches separately.

i.) The argument against prison treatment

One argument against treatment of addicts in prison is that the roots of addiction are social rather than psychological. Newman (1977) summarised the argument against prison treatment, which attacks the provision of psychological therapies for addicted
prisoners. He pointed out that these 'clients' were not mentally ill and thus not in need of psychotherapy; that involuntary treatments had failed in the past; that there was potential for abuse of staff-client relationships because of the power of treatment personnel over captive clients; that therapists were unable to maintain independence from gaol administration, precluding the establishment of genuine therapeutic relationships and that resources required for gaol treatment programs should be spent elsewhere.

Instead of gaol-based drug treatment Newman (1977) advocated adequate detoxification, humane custody, education and vocational training and referral to relevant community services. However his main concern was that the possession and use of drugs should be decriminalised.

A second argument against prison-based treatment holds that even if treatment of perceived psychological problems is commenced, it is doomed to fail because of the conflict between prison security requirements and the ethics of therapy (e.g., Garner, 1978; Smith, Bearnish and Page, 1979).

ii.) Access to programs available in the community

In a survey of drug programs available in Australian and New Zealand corrections (NSW Department of Corrective Services, 1989) it was found that, at the end of August 1989 all jurisdictions were supporting the use of community-based helping organisations, such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.). New Zealand, in particular, were making extensive use of outside community agencies for drug and alcohol work inside prison.

The New Zealand Department of Justice (1988) has stated that it: "favours a treatment and education approach which makes use of resources and facilities existing in the community rather than prisons attempting to duplicate these within the prison setting" (p. 287).

Beside avoiding duplication, another significant advantage of programs such as A.A. is that they exist in many locations in the community hence inmates are able to continue the program following their release.

iii.) Specialised prison-based programs

The use of resources and facilities existing in the community, however, does pose its own problems. Drug treatment agencies in New Zealand, for example, were found not to have the resources to meet the needs of the Criminal Justice System. It has been suggested that "firstly, the size of the population is too great to be adequately met by existing services, and secondly, the needs are possibly different from those of other
groups and may therefore require special programmes" (New Zealand Department of Justice, 1988, p. 289).

Proponents of prison-based treatment generally adhere to a psychological model of drug abuse: they hold that changes to an individual’s attitudes, beliefs and values can change relationships, lifestyles and drug-taking behaviour.

Many different kinds of programs have been implemented in prisons: drug education, counselling, work programs, self-help groups, group therapy, therapeutic communities and/or other residential programs, sojourns away from the prison and methadone treatment.

The majority of these categories are self-explanatory, resembling community-based programs. The one exception to this is the Swedish "sojourns away from the prison". Because this type of program is not well known in Australia, I shall read Bishop’s description of this program. Bishop (1988) described how prisoners in Sweden:

"may be allowed to reside away from the prison if by so doing they can take part in some activity which will substantially improve their post-release adjustment prospects. Sojourns away from the prison can be granted from any prison and, with the exception of a handful of exceptionally dangerous prisoners, can be granted to any prisoner. The sojourn may be started at any time during the stay in prison and may be of any length. The sojourn can continue after release from prison. Time on the sojourn counts as prison time served."

About 700 prisoners per year are granted permission to reside away from the prison. At least three-quarters are drug misusers. They are mainly placed in therapeutic communities run by private trusts and the municipalities, or go to specially selected families. These latter are often small farmers. The prisoner lives alongside the family and shares its work and leisure. The families themselves are essentially ‘ordinary’ people who yet become rapidly skilful in handling drug-misusing prisoners. It is important to ensure that the families are backed up by skilled social workers who must be available for crisis intervention round the clock. The families are paid for their services. There are regular rest periods when the family is not required to have a misuser in residence but still receives payment." (p. 196)

Although there are exceptions, drug treatment programs in prison have tended to be "rather homogeneously designed to deal with a broad category of ‘drug abuse’ and not highly differentiated in terms of population group or nature of drug abuse problem" (Salmon & Salmon, 1983, p. 18). As Salmon & Salmon point out, this practice may be in error. It may be more useful to develop treatment approaches appropriate to the
group and problem being dealt with.

2. Judging program success

In light of the range of programs tried, the next question is how can one judge the success or relative success of these programs. First one must define "success" and then one must measure it.

In examining specialised prison-based programs for drug users, it must be recognised that these programs are not a homogeneous category: not only do they differ in their treatment strategy (e.g., education programs versus counselling versus methadone maintenance, etc), structure and activities, they differ in their aims and the criteria against which their success can be measured.

Where specialised prison-based drug programs are run, they can be run for a number of different reasons. Some programs focus on behaviour in prison, others focus on behaviour following release. Some seek to change needle-sharing as a means to decrease the risk of transmission of Human Immunodeficiency Virus, some seek to change drug use, some seek to change criminal behaviour, others seek to change a combination of these behaviours. Possible objectives for prison-based drug programs include:

- to reduce/stop drug use in gaol
- to reduce/stop drug use following release from gaol
- to reduce/stop needle-sharing in gaol/in community to decrease risk of HIV infection
- to reduce criminal behaviour on release.

These different objectives, in turn, lead to the success of the programs being judged against a range of possible criteria. Some of the criteria against which the success of different prison-based programs for drug users have been measured include: prisoner self-esteem (Field, 1985), information learnt (Field, 1985), abstinence from drugs while in the community (Hume & Gorta, 1988b; Vaillant & Rasor, 1966; Vaillant, 1973), use of community drug treatments (Platt, Perry & Metzger, 1980), taxable income (Bishop, 1988) and recidivism (Callahan, 1971; Bishop, 1988; Hume & Gorta, 1989; Rouse, 1991). When looking at an individual criterion such as recidivism we find that it is measured in different ways in different studies, for example:
number of arrests (Platt, Perry & Metzger, 1980; Salmon & Salmon, 1983; Wexler cited in Gendreau & Ross, 1987);
convictions (any offence) during 3 year follow up period (Field, 1985);
return to gaol (Gorta 1987a; Field 1985 (during 3 years after release); Hume & Gorta, 1989);
number of days in prison during follow-up period (Bishop, 1988; Hume & Gorta, 1989).

The use of such different criteria for judging programs' success makes it difficult to compare the relative effectiveness of different programs (cf. Salmon & Salmon, 1983).

3. Requirements for an evaluation

Next I would like to outline the requirements for an evaluation of a prison-based drug program, or any other program for that matter, and provide examples of how the dynamics of prison systems can hinder the conduct of informative evaluations.

Evaluations can be "process", "product" or both. "Process" evaluations usually describe the program administration and delivery to determine whether the program is actually delivered, whether it operates in accordance with specified policy and, if not, what obstacles get in the way. The broad aims of the "product" or "outcome" evaluations are to examine whether the program achieves the results it sets out to achieve, e.g., whether the individuals who participated in the program were less likely to commit crime, less likely to use illegal drugs, had increased their life skills, etc. Both types of evaluation are important: if a program does not deliver the results it is important to know why. In this paper, however, I shall concentrate on outcomes.

The requirements for an outcome evaluation of a (prison-based) drug program are:

- that there exists a defined drug program with aims which are understood and shared by those involved with the program;
- that the achievement or otherwise of the aims is measurable;
- that records are kept both for those who experience the program and for a very similar group of people who do not experience the program;
- that the program runs in a relatively unmodified way for long enough to assess the format of the program;
- that sufficient people complete the program (& sufficient remain in the control group) so that statistical analysis can be used to determine whether differences in outcome between those experiencing the program and others are likely to be due to chance fluctuation or to some aspect of the program.

The reality is that we often do not have ideal programs to evaluate. Programs are run in
less than perfect situations by persons who are not "super people" and who do not necessarily combine expertise in all of the areas of drug and alcohol treatment, management, administrative and research skills as well as an understanding of prisoners and the necessary restraints of working in a gaol. Program administrators, like all people, have both strengths and weaknesses. When evaluating prison-based drug programs it must be remembered that the "results" of these programs reflect not only the philosophy and structure of the program itself, but also the skills and abilities of the staff involved and features of the environment in which the program is run. Care must be taken that potentially useful programs are not dismissed when their lack of achievement might be the result of, say, lack of staff training.

i.) Looking at the first requirement - 'that there exists a defined drug program with aims which are understood and shared by those involved with the program'

An example I would like to give is Stathis and Conolly's (1990) retrospective study of the Parklea Drug Unit, which operated from December 1985 to May 1989. The Parklea Drug Unit was an attempt to develop a drug-free therapeutic community among a number of inmates, with histories of drug abuse, within the walls of a maximum security gaol in NSW. The treatment in the Drug Unit depended on a multi-disciplinary team effort. Treatment lasted for a period of three months. Eight inmates participated in the program at any one time.

In their study, Stathis and Conolly found that:

"The Drug Unit was set up without a detailed conceptualisation of aims and objectives nor any clear management guidelines for staff at Parklea" (p. 8).

Furthermore they found that non-custodial and custodial staff differed in their perceptions of the goals and aims of the Drug Unit. They found that non-custodial staff thought the Parklea Drug Unit should help to provide inmates with the following personal attributes: self-esteem; self awareness (with particular relevance to awareness of drug use); communication skills; responsibility for actions; and lifestyle choices. Custodial staff, on the other hand, were more likely to perceive that the goal of the Unit was to make prisoners drug-free. Where custodial staff did respond that the aim of the Drug Unit was to make inmates "better people", they felt that this entailed making them more productive to society (Stathis & Conolly, 1990, p. 30).

This lack of documentation and confusion over aims is not surprising when one considers all that is involved in implementing a totally different type of program in a regimented environment such as a gaol. It can be seen to be more important to get staff into place and the program operational. Documentation, while seen as important, is seen as something which can always be put off just a little longer. New programs evolve as
potential operational problems are discovered, staff turnovers lead to further confusion about aims and objectives.

While lack of documentation and confusion over aims may not be unexpected, it makes evaluation very difficult. It is not possible to evaluate a program when one does not know what the program does. One cannot determine whether it has been successful, if one doesn’t know what the program is seeking to achieve.

ii.) ... the second requirement - that achievement or otherwise of the aims is measurable

Field (1985) described the Cornerstone Program which is a pre-release therapeutic community for alcohol and drug dependent prisoners in Oregon. The Cornerstone Program is described as an intensive 32-bed residential program with a six month follow up after-care program. In his evaluation he measured a number of variables including: changes in inmate self-esteem; changes in staff ratings of the inmates’ psychiatric symptoms; improvement in knowledge of the information contained in the education modules of the program; number of participants who were convicted of a further offence and/or reimprisoned during a three year follow up. Although he was able to obtain all of these measures, Field also noted that while use of alcohol or drugs after treatment is certainly an important outcome variable, it is extremely difficult, and perhaps impossible, to measure reliably (p. 54).

Another example I would like to give is the NSW Prison Methadone Program. The objectives of this program have changed markedly since the program commenced operation in April 1986. Among the current objectives is:

"to reduce the spread of Human Immunodeficiency Virus and Hepatitis B virus amongst prisoners".

This objective is obviously difficult to evaluate because of the lack of reliable data on the spread of HIV or Hepatitis B prior to the methadone program. Moreover there is a lack of reliable data on either the extent of needle use, or the extent of these viruses within the prison system and/or general community.

The reality is that some program objectives will always be more ambitious than we have skills to measure. This, however, results in our not being able to determine whether the program has been successful in meeting such objectives.
iii.) The third requirement - that records are kept both for those who experience the program and for a very similar group of people who do not experience the program.

In order to know whether prison-based treatment makes a difference or not one would like to be able to compare how the prisoners who participated in any program would have performed had they not participated in the program. While it is not possible for an individual inmate both to participate and not participate in a program at the same time, a research methodology known as "random allocation" or "random trials" is used in some evaluation studies so that two (or more) groups are formed such that there is no reason to believe that the inmates in the two groups differ in any systematic way. Under random allocation methodology one group would participate in the program and the other (the "comparison" or "control" group) would not. Any subsequent difference in performance (e.g., offending, drug taking, etc.) would then be attributed to the effects of the program.

Many of the studies reported do not involve a control or comparison group. While we are able to monitor how those in the program behaved after the program, we are not able to judge how they might have performed had they not participated, hence we are not able to evaluate what effect the program had.

Some studies incorporate comparison groups which are subsequently considered not to be comparable to those who participated in the program. Field (1985) provided three potential comparison groups against which to measure the recidivism of those who completed the Cornerstone program. The first comparison group included those who dropped out of the program. Field noted "however, their self-selection out of the program may be due to particular factors that also influence recidivism" (p. 54). The second comparison group did not have the chronic substance abuse nor the chronic criminal histories of the Cornerstone graduates. The third group was based on a sample taken from a "similar population" by other researchers at a different time. Not enough information was provided to know how similar or dissimilar this other population actually was.

In other studies authors admit comparison groups are not possible. Bishop (1988) stated that in the evaluations of the 'sojourn from prison' program "completed" cases were compared with "interrupted" cases because an experimental design incorporating a control group was not possible. As was the case for Field, the interrupted cases could differ from the completed cases on variables related to recidivism.

Finding a suitable comparison group is a common problem.

While it is well understood that random allocation of prisoners to the program and to a
control group would be necessary to test the effectiveness of a program which is run in gaol, such random assignment is often considered undesirable or politically unfeasible by program administrators. Even though the potential effects of the program are untested, it is frequently considered more desirable to be able to "offer everyone who is interested" something, rather than offering half of them nothing. If two programs were trialled simultaneously, and prisoners randomly allocated to the two programs, it would be possible to see which is the more effective, although unless there is a control group it is not possible to test whether either is more effective than doing nothing at all.

iv.) ... the fourth requirement - that the program runs in a relatively unmodified way for long enough to assess the format of the program

As mentioned previously, the aims of the NSW Prison Methadone Program have changed dramatically since the program commenced in April, 1986.

Initially the program focussed on 'improving levels of social/behavioural functioning' and 'breaking the cycle of criminal activity associated with drug use'. However, with the growing concern about the incidence of HIV, the philosophy of methadone maintenance in prison moved towards an AIDS prevention strategy. The program's objectives were revised initially in October 1987 and then again in August 1989. There was no mention of the earlier objectives of 'improving levels of social/behavioural functioning' or 'breaking the cycle of criminal activity associated with drug use' in these revised objectives.

Such major changes to the nature of the program which involve staff assessing prisoners for entry to the program for different reasons, at different (but not well-defined) times makes evaluation difficult.

v.)... the final requirement - that sufficient people complete the program (& sufficient remain in the control group) to enable statistical analysis of the differences

Even if the program being evaluated had no effect, one would expect the behaviour of those in the program to be slightly different from that of those in a comparison group. Statistical analysis provides a technique which enables one to decide whether the differences in outcome between those experiencing the program and others are likely to be due to chance fluctuation or to some aspect of the program. However, to use statistics the sample must be "large enough".

In a study of The Wharton Tract Narcotics Treatment Programme, a therapeutic community for heroin addicts in prison, data were analysed on 1600 inmates experiencing the programme of over the period 1970-1977 (Platt, Perry and Metzger,
Male addicts, aged 19 years and over, participated in group therapy (guided group interaction and interpersonal problem solving group therapy), took personal responsibility within the unit, made self evaluations, experienced peer review and graded release. A two year follow-up on parole revealed that participants had significantly fewer arrests, a lower re-commitment rate, slightly higher use of community drug treatments and lower use of heroin, as perceived by parole officers, than control subjects. These are promising findings, but methodological problems raise some doubts about their usefulness. The control group was not randomly assigned and selection biases may have been operating to make participants "better risks" for the programme and for release. Although 1600 inmates experienced the programme, only 48 participants and 18 control subjects completed the psychological questionnaire.

An example of a study which did randomly assign participants to "experimental" and "control" groups, was a study of an alcohol education course focussing on pre-release young offenders in Noranside in the United Kingdom (Baldwin, 1991). Twenty-seven young offenders took part in the study: fourteen attended the program and the other thirteen were to be used as a control. While all fourteen of those who participated in the program were able to be followed up, only seven of those in the control group were able to be followed up an average of 14 months later.

Such numbers are too small from which to draw useful conclusions.

4. Emerging themes

i.) Duration of participation is important

Though estimates of the optimal duration vary, the estimates tend to range from 6 months to 2 years.

Gamer (1978) described a study by the Prison Service in Hong Kong which sought to determine the period of time required for treatment. Over a period of ten years, treatment was given to more than 15,000 convicted prisoners found to be drug dependent on admission to prison for the length of their sentence, which ranged from several weeks up to maximum of three years. The findings were reported to indicate that "a minimum period of six months to a maximum of 18 months was the most appropriate" (p. 208).

Visher (1990), in an overview of treatment effectiveness, suggested that 1 to 2 years was the optimal duration (cf. p.5).

Rouse (1991) cited a study by Wexler, Lipton and Foster (1985) which found that the optimum time for participation in a prison therapeutic community was 9-12 months. Benefits declined for those in the program longer than 12 months.
ii.) The importance of the inmate's motivation

Linked to duration of program participation, is the question of the inmate's motivation. Inmates who are not interested in changing their lifestyle are unlikely to remain in a program.

Garner (1978) has written that the role of prison-based programs is to motivate an inmate to change his behaviour:

"Ultimately, it is the individual under treatment who will decide whether or not he or she will revert to drug use; thus the period for which they are detained can be used to encourage them to make a decision which will enable one to live within the community after discharge without dependence upon drugs" (p. 206).

Inmates seem aware of the importance of their own motivation. Studies in NSW (Miner & Gorta, 1986; Bertram & Gorta, 1990a) have found that more than one-quarter of the prisoners with drug histories interviewed, stated that there is no treatment program which would be able to help them while they are in gaol. Miner and Gorta probed further and found that this was either because they thought that nothing would work in a gaol setting (17%) or because no program could work unless they had made up their minds to stop (12%).

iii.) The need for post-release support

Provision of post-release support links in with the notion of "relapse prevention", whereby, as described by Gendreau and Ross (1987), "one should focus interventions on the reasons why individuals fail to maintain positive changes after they demonstrated success during treatment. Therefore, relapse prevention is crucial for any long-term effects of treatment" (p. 385).

One of the ten studies which we have conducted about different aspects of the NSW Prison Methadone Program focussed on "failures" on the program - those who returned to gaol (Bertram & Gorta, 1990a). We analysed these prisoners' self-reported explanations of what had gone wrong.

The study included those people released from gaol on methadone between April 1986 and 30th June 1988 who had been reincarcerated and were currently in gaol during the period between 24th July and 31st August 1989. In order to determine whether the reported problems being faced on release were specific to those released on methadone or were common to all prisoners, the responses to a variety of questions were compared.
to those of a comparison group.

Principal findings from this study were as follows. The majority of the inmates in the sample (72%) reported committing their current offence(s) for financial reasons, this was either to support their drug habit (42%), for personal financial reasons (24%) or a combination of both these reasons (6%). Those released on methadone stated experiencing similar problems to those not released on methadone. These problems included: day-to-day aspects of life such as finding accommodation, employment and managing finances (50%), adjusting from the restricted gaol environment to the community (48%) and experiencing the need to use drugs (32%).

Despite these people returning to gaol, most inmates (87.1%) stated that methadone helped them stop using or reduced their heroin use. Three-quarters of these inmates (77.4%) reported that methadone aided them in reducing the number of crimes they committed, either specifically because it reduced their habit or more generally because they experienced a change in lifestyle. Hence we come back to the question of how does one determine whether or not a program is successful.

The fact that drug issues are mentioned by only a third of the sample as a problem faced on release, whereas other issues such as day-to-day problems and adjustment from gaol into the community are mentioned more frequently, each by fifty per cent of the sample, may be evidence to reinforce the idea that drug issues are secondary to these underlying problems. Inmates talk about being prepared to deal with their heroin addiction, being aware of the problems and pitfalls associated with it but being poorly prepared to be responsible for themselves financially or emotionally and unprepared for the lack of support from the general community.

It would seem that for prison-based programs to affect post-release behaviour, transitional support is required. The need for post-release support has also been noted elsewhere (e.g., Garner, 1978; Visher, 1990; Wallace et al, 1990).

iv.) Recipes for success

A number of writers have provided a variety of suggestions for what is required for the successful implementation of in-prison drug treatment programs. When considering these suggestions it should be remembered that while some useful strategies pertain to all types of drug programs, others will depend on the type of program to be run and the cultural background of the prisoners and the prison system. The authors differ in their ingredients for success. Examples of their suggestions are provided below.

Wexler, Blackmore and Lipton (1991) prepared a set of ten general principles of successful intervention based on "their collective clinical experience in the field of drug
abuse treatment in corrections and an exhaustive review of the existing drug abuse research and treatment literature". Examples of their principles of successful intervention include:

"Separate participants from general population as soon as possible";

"Establish clear, unambiguous rules and consequences for breaking such rules";

"Employ ex-offender/ex-addict staff to serve as role models" (p.475).

They also provided thirteen guidelines for the implementation of correctional treatment programs, including advice such as:

"Prepare the institution's management and staff for the initiation of any modifications to the program with presentations and distribution of informational materials well in advance of implementation";

"Employ skilled, experienced and committed clinicians, administrators and researchers" (pp. 476-477).

Garner (1978, p. 212) From his experience with prison-based programs in Hong Kong has suggested:

"the less hospital orientated the setting, the better";

"the treatment program must be directed in such a way that the addict realises beyond any doubt that he himself is responsible for making most of the going";

"regular daily routine, coupled with work of mainly a physical nature, ... insofar as it is possible, such work should take place outside of the treatment centre perimeters involving community projects through which those under treatment can demonstrate their usefulness to the community and at the same time take pride in being gainfully employed";

"another very important factor in the treatment process and probably the main one involves the calibre of the staff. A treatment program can be carried out in buildings, new or old, lavish or cramped, but ultimately it is the staff who hold the key to its success".

Smith, Beamish and Page (1979) emphasised: openness; well-developed lines of communication between the drug unit and other sections of the prison and a carefully established structure.
Visher (1990) recommended extensive planning and ongoing co-operation with correctional authorities (p. 6).

Chaiken (1989), when comparing four U.S. programs which reported "relatively low rates of recidivism among program participants", suggested that eleven components were essential to good program outcomes, including:

"having a special source of funds, administered separately from other correctional services";

"use a comprehensive approach and a wide range of activities";

"preparation of participants for future problems, including family and job problems".

Stathis and Conolly (1990) used the knowledge that they gained about the Parklea Drug Unit to propose broad recommendations relevant to the management of any therapeutic drug unit in prison. Examples of their recommendations included:

"the goals and aims of any drug therapeutic unit should be clearly defined at the onset for all staff and inmates. In particular the term 'addiction' and the type of drug problems to be treated need to be defined";

"ensure that the roles of each staff member are clearly defined";

"clear lines of authority should be instituted";

"ensure that both custodial and non-custodial staff are adequately trained and prepared for their role in future drug programs".
In summary:

1. We are aware of a range of prison-based programs that have been tried. Our knowledge of treatment programs is limited to those programs described in published papers, conference papers to which we have access and those we know about from personal communication.

2. Running prison-based drug treatment programs is an area which is still in its infancy, beginning in the United States in the late 1960s. In NSW such programs did not commence until the mid-1980s.

3. When examining drug treatment programs one should not pool them together. They differ not only in their treatment strategy, structure and activities, but they also differ in their aims and the criteria against which their success can be measured.

4. Monitoring occurs for many programs measuring, for example, attendance levels, numbers completing the program, measures of post-program recidivism, etc.

5. There have been relatively few evaluations attempted. Some studies have been conducted using comparison groups where it is not clear how comparable those in the comparison group are to those who participated in the program (e.g., those who completed versus those who did not complete).

6. The lack of studies incorporating a randomised control group leaves us unable to tell whether prison-based treatment really makes a difference or whether it is worth providing any programs for drug users in prison.

7. The lack of random assignment and the use of different criteria for the success of different programs leaves us unable to say that one program is more successful or more effective than another.

8. This paper does not claim that programs for drug users in prison are unsuccessful. Rather, it is claimed that they are untested.

9. Despite the lack of evaluations, reviewers (e.g., Chaiken, 1989; Visher, 1990) have stated that there can be many positive outcomes of such programs, such as reductions in recidivism, an improved working environment for staff and positive publicity for the correctional system.
Bibliography


New Zealand Department of Justice (1988) Prisons in Change. The Submission of the Department of Justice to the Ministerial Committee of Inquiry into the Prisons System.


