

# Sanctions and Rewards in Prison-Based Therapeutic Community Treatment

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**IN RESPONSE TO** the increasing numbers of offenders incarcerated for drug-related offenses, the last two decades have witnessed a significant expansion in prison-based substance abuse treatment. Although a variety of approaches to treating substance-abusing inmates have been developed, the most common treatment modality used in prisons is the therapeutic community (TC). It is also the modality that has received the most attention from researchers in recent years.

Evaluations of prison-based TC programs conducted in several states and within the federal prison system have provided empirical support for the continued development of these programs throughout the nation. Findings from these studies indicate that prison-based TC treatment is effective at reducing recidivism and relapse to drug use, especially when combined with continued treatment in the community following release from prison (e.g., Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Wexler, De Leon, Kressel, & Peters, 1999; Wexler, Melnick, Lowe, & Peters, 1999). Overall, when the findings of TC treatment studies are standardized and combined using meta-analytic techniques, the weighted mean effect size for recidivism (using the *r* index) is .13, which can be

interpreted as a 13 percent difference in recidivism between those who received TC treatment and those who received no or minimal treatment (Pearson & Lipton, 1999).

Although the research on TC treatment programs indicates that this approach can be effective at reducing recidivism and relapse, given the relatively small effect size associated with the TC treatment approach, it is clear that there is room for improvement. One possible target for improving the outcomes of prison-based treatment programs is client motivation and participation in treatment.

As is the case with substance abuse treatment with criminal justice populations in general, participation in prison-based substance abuse treatment programs often involves some level of coercion. In some cases, it is mandated.<sup>1</sup> In addition, especially in prison-based programs where treatment participants are not fully segregated from the general population, the prison subculture often actively and openly discourages inmate participation or engagement in treatment programs. As a result, treatment providers must deal with clients who have low levels of motivation for treatment and who remain unengaged in the treatment program. Many inmate participants, especially those who are mandated into treatment or who remain exposed to the negative influences of the prison subculture, often exhibit

high degrees of resentment and resistance to efforts to engage them in program activities. Some may even deliberately disrupt programming activities, thus negatively impacting the ability of the treatment provider to deliver effective treatment services to those who are motivated and engaged in the treatment program.

The challenge for treatment providers, therefore, is to develop innovative ways to overcome this resentment and resistance; to effectively discourage behaviors that are disruptive to the treatment program, while at the same time encouraging behaviors that promote client participation and engagement in the treatment process. This paper will explore the roles that sanctions and rewards play in promoting client motivation and involvement in prison-based TC substance abuse treatment programs.

Sanctions for inappropriate behavior take the form of TC sanctions (e.g., behavior contracts, learning experiences, pull-ups) or correctional sanctions (e.g., documented disciplinary actions, loss of credited time, administrative segregation); inmates are often subjected to both types of sanctions for the same behavioral transgression. This practice of "double sanctioning" can have a negative impact on client morale and motivation and treatment effectiveness, especially when TC and correctional staff apply sanctions inconsistently. This paper presents a proposed model for

<sup>1</sup>The distinction is that coerced treatment allows for some degree of choice on the part of the inmate, whereas mandated treatment does not.

assessing behavioral transgressions and eliminating inconsistencies in the administering of TC and correctional sanctions.

Systems that reward appropriate behaviors among inmate-clients are largely non-existent or are under-utilized in prison-based substance abuse treatment environments, but can serve to promote motivation and involvement in treatment program activities when properly structured and administered. The use of behavioral reinforcement approaches for promoting client participation and engagement in treatment will be discussed.

## Sanctioning Inappropriate Behavior

By their nature, correctional environments enforce compliance with institutional rules and codes of conduct through negative sanctions—the punishment to individuals who engage in behaviors that violate institutional rules and codes of conduct. Within the context of prison-based treatment programs, behavioral transgressions must usually be reported to correctional staff, regardless of their severity. Standard operating procedures of prisons demand that behavioral transgressions coming to the attention of any staff member must be reported and sanctioned in accordance with the existing institutional sanctions protocol. This process is deemed essential to maintaining order, safety, and security among inmates and staff in the correctional setting.

Similarly, TC method prescribes a system of graduated sanctions, ranging from “verbal correctives” to “disciplinary actions,” that are to be used to respond to behavioral transgressions within the community environment. The TC method teaches that sanctions (along with privileges) are an integral part of an interrelated system that TCs use to express the extent to which the community approves or disapproves of individual members’ “behaviors and attitudes concerning the norms of daily living, recovery, and right living teachings of the TC” (De Leon, 2000, p. 211). As such, treatment staff in prison-based TCs often place a priority on imposing *TC sanctions* as opposed to standard *correctional sanctions* when responding to behavioral transgressions.

Institutional policies that require the reporting of behavioral transgressions and prescribe the types of sanctions that are to be administered thus exist alongside the desire of treatment staff to use the system of graduated TC sanctions to promote, sustain, and reinforce the TC culture. As a result, inmate-clients may be subjected to two sanctions for a single behavioral transgression, one imposed by corrections officials in accordance with institutional policy, and the other imposed by TC staff

(or members) in accordance with TC philosophy and method. Given the underlying rationales for both types of sanctions, the practice of “double sanctioning” may not be avoidable and, indeed, administering both correctional and TC sanctions may serve complementary purposes, especially in prison-based TCs where clients are not fully segregated from the general prison population. Correctional sanctions serve the purpose of ensuring order, safety, and security within the larger prison community. TC sanctions serve the purpose of promoting, sustaining, and reinforcing the existence of a therapeutic culture in the treatment environment.

From the inmate-client’s perspective, however, this distinction may not be obvious or clearly delineated. As a result, the inmate-client may view double sanctioning as unfair and indicative of a lack of coordination and communication between treatment and institutional staff. These feelings are reinforced, and to some extent justified, when correctional and TC sanctions are applied inconsistently for the same behavioral transgression. This is likely to happen if treatment and correctional staff hold different views regarding the severity of a particular behavioral transgression. Given that the type of sanction administered is generally dependent on the severity of the transgression, the inmate-client may be subjected to sanctions that differ in terms of their severity for the same transgression (e.g., a verbal warning from a correctional officer versus a loss of phase status by the TC, or loss of good time credit as a correctional sanction versus a behavioral contract as a TC sanction).

To counter this perceived unfairness, the distinction between correctional and TC sanctions and the rationale behind administering both types of sanctions should be clearly communicated to inmate-clients at the time they enter treatment. Just as important, treatment and correctional staff should communicate with each other when behavioral transgressions occur, agree on the severity of the transgression, and agree on their respective responses to ensure that the two types of sanctions (if any are to be applied) are applied consistently. Without some level of ongoing communication and coordination between treatment and custody staff, independently assessing behavioral transgressions and deciding which sanctions to administer is certain to result in inconsistencies in the application of TC sanctions by treatment staff and correctional sanctions by custody staff, further compounding clients’ resentment and resistance to the treatment program, treatment staff, and institutional authority.

Establishing guidelines or a protocol that can be agreed to and followed by both treatment and custody staff for assessing behavioral transgressions and deciding upon appropriate sanctions can significantly reduce or eliminate disparities in the application of sanctions and (as a result) have a positive effect on offenders’ participation in treatment (Tonry, 1998). The following decision-making model represents only one example of how treatment and custody staff can come to a consensus on sanctioning inappropriate behaviors, thus eliminating inconsistencies in the severity of TC and correctional sanctions that are applied in response to behavioral transgressions. Once treatment and custody staff have agreed on a model to be used, it is important that they maintain some level of consistent ongoing communication to assess its usefulness, identify problems or shortcomings with it, and develop and implement changes where desired or needed. Periodic training sessions should be held with both treatment and custody staff to train new staff on the use of the model, and train existing staff on any modifications that have been mutually agreed to and implemented.

## A Sanctions Decision-Making Model

Within both correctional environments and TCs, sanctions for inappropriate behavior can be viewed as lying along a 5-point continuum ranging from mild to severe (Level 1 to Level 5; see Table 1). Mild sanctions (Level 1) are most often undocumented verbal admonishments (correctional sanction) or pull-ups (TC sanction). Intermediate sanctions (Level 3) consist of documentation of an institutional rules violation that becomes part of an inmate’s permanent file (correctional sanction) or a learning experience or behavior contract (TC sanction). Finally, severe sanctions (Level 5) consist of loss of good-time credit and/or transfer to an administrative segregation unit (correctional sanction) or banishment from the community (TC sanction).

Whether the sanction is being initiated by a member of the treatment staff or a member of the custody staff, any decision to initiate a sanction against an inmate for inappropriate behavior involves a certain amount of structured discretion to determine the level of sanction imposed (Taylor & Mason, 2002). This structured discretion is independently exercised by treatment staff and custody staff in different environments (i.e., prison versus treatment) that have different and often conflicting philosophies and policies to guide and influence staff decisions about applying sanc-

**TABLE 1**  
*Sanction Types*

Level	Correctional	TC*
1	Verbal (not documented)	Verbal pull-ups
2	Verbal (documented)	Bookings
3	Administrative rules violation	Learning experiences
4	Serious rules violation	Loss of phase status
5	Administrative Segregation	Banishment

\*Source: De Leon (2000)

tions (e.g., institutional rules and regulations governing inmate behavior within the institution and TC house and cardinal rules governing behavior within the treatment environment).

When exercising discretion, however, both treatment staff and custody staff will often take into account similar factors that are related to the behavior exhibited. Primary among these are 1) the *seriousness* of the behavioral transgression; 2) the *frequency/pattern* with which a particular behavioral transgression occurs; and 3) the *unexpectedness* of the transgression; the degree to which the behavioral transgression was expected, given existing events or circumstances.

When assessing the *seriousness* of the behavioral transgression, the individual initiating the sanction looks at factors such as: Was the behavior threatening or injurious to others? Was it legal or illegal behavior? Did the behavioral transgression produce a victim, or was it a victimless transgression? Did the individual committing the transgression voluntarily disclose or confess to the behavior, or did it come to the attention of others (i.e., treatment or correctional staff) by some other means?

When assessing the *frequency/pattern* of a behavioral transgression, the individual initiating the sanction considers factors that help him/her decide if the behavior is exhibited frequently or if it represents a pattern of behavioral transgressions. To determine this, the individual will consider such questions as: Has the person engaged in the same or similar behaviors in the past? How much time has elapsed since the last occurrence of the same or a similar behavioral transgression? Does the behavior represent an overall pattern that needs to be addressed?

Finally, when assessing the *unexpectedness* of the behavioral transgression, the individual administering the sanction looks at such factors as: Was the behavior considered normal for the individual? (Individuals who are dually diag-

nosed may be more prone to exhibiting certain behaviors that would otherwise be considered inappropriate.) Are personal issues or events involved that may explain the behavior? For example, the recent death of a friend or family member or receiving bad news from home may trigger feelings of depression or anger that manifest themselves in inappropriate behavior that is otherwise uncharacteristic of the individual.

The weight given to each of these three factors may vary depending on the particular behavioral transgression and who is assessing it (treatment or custody staff). However, it is likely that the seriousness of the behavioral transgression will receive the most consideration, since it more directly reflects the actual behavior exhibited. Thus, it is likely to carry more weight than the other two factors.

Consistent with this, more weight is given in this model to the seriousness of the behavioral transgression than to its frequency/pattern and unexpectedness. This is accomplished by allowing staff to assign higher values to the seriousness factor. Seriousness lies on a 10-point continuum (not serious at all=1 to very serious=10), whereas the frequency/pattern and the unexpectedness of the behavioral transgression lie along 5-point continuums, ranging from not at all frequent or unexpected (1) to very frequent and unexpected (5).

When a behavioral transgression occurs, treatment and custody staff should communicate with each other and reach a consensus on where the behavioral transgression lies along each continuum by agreeing on a point value to assign for each of the 3 factors (i.e., 1-10 for seriousness and 1-5 each for frequency/pattern and unexpectedness). Once this has been completed, the average of the three point values is calculated and rounded to the nearest whole number. Given the total population of point-value combinations (N=250), possible average scores range from 1.0 (i.e., a value of 1 assigned to each factor) to 6.7 (i.e., a value of 10 assigned to seriousness, 5 assigned to frequen-

cy/pattern, and 5 assigned to unexpectedness). The distribution of possible average scores rounded to the nearest whole number and the level of sanction to be applied based on the mean rounded scores are shown in Table 2.

As stated above, this model is only an example. Variations are possible. For example, treatment and custody staff may decide on fewer levels of sanctions (e.g., 3 rather than 5). In addition, other factors not considered in this model can be included and assigned a range of possible point values. Also, treatment and custody staff may agree that certain behaviors (e.g., physical violence against another person) or any behavioral transgression that is assigned a seriousness point value greater than 7 should automatically receive a Level 4 or 5 sanction, regardless of how infrequently the behavior has been exhibited in the past, how unexpected it was, or any other extenuating circumstances. The most important point is that treatment and custody staff agree on the model to be used, communicate with each other whenever a behavioral transgression calls for sanctioning, and apply consistent levels of sanctions for the same behavioral transgression.

## Reinforcing Appropriate Behavior

As discussed above, correctional environments favor the use of negative sanctions (punishment) to enforce compliance with institutional rules and codes of behavioral conduct. Seldom, if ever, do inmates receive positive reinforcement for engaging in pro-social behaviors (i.e., complying with institutional rules and codes of behavioral conduct). This was confirmed in a series of focus groups conducted with treatment participants and treatment staff at five prison-based sub-

**TABLE 2**  
*Sanction Types*

Mean Score (rounded)	Possible Occurrences*	Sanction Level
1	4	1
2	31	1
3	65	2
4	74	3
5	56	4
6	19	5
7	1	5

\*N=250

stance abuse treatment programs in California, where treatment participation was mandated for eligible inmates. Both the participants (inmates) and treatment staff stated that there was too much reliance on punishment, and that the use of incentives or rewards in the treatment process would help to alleviate the resentment and resistance among the participants that resulted from being mandated into the treatment programs (Burdon, Prendergast, & Frankos, 2001).

Within prisons, most treatment programs discipline disciplinary actions against inmates who violate institutional or program rules, but often place little emphasis on rewarding specific acts of positive behavior (e.g., punctuality, participation, completion of treatment plan tasks). This appears to be primarily an artifact of the organizational reality that finds treatment programs operating within larger bureaucratic systems (corrections departments) that possess and promote a fundamentally different philosophy and policies regarding management of inmate behavior. Rewards, when they occur, most often take the form of verbal praise from a counselor or positive verbal peer comments (e.g., "push-ups" in the TC model of treatment; De Leon, 2000). More tangible reinforcement for positive behavior may take the form of moving a client to the next phase of the treatment program or conferring on him/her additional privileges. However, these types of reinforcement "tend to be intermittent and, in contrast to sanctions, less specific, not immediately experienced, and based on a subjective evaluation of a client's progress in treatment" (Burdon, Roll, Prendergast, & Rawson, 2001, p. 78).

## Behavioral Reinforcement Approaches

The fundamental principle of behavioral reinforcement is the systematic application of positive reinforcement following demonstration of the desired behavior. Specifically, the delivery of a positively reinforcing "event" contingent upon the performance of a specific behavior results in the increased frequency of the specified behavior. The use of reinforcement for increasing desired behaviors has a long tradition of application in the behavioral literature (Bandura, 1969; Ullman & Krasner, 1965) and, more specifically, in alcohol and drug treatment (Higgins, Alessi, & Datona, 2002; Leibson, Tommasello, & Bigelow, 1978; Meyers & Smith, 1995; Miller, 1975), where this practice has been termed contingency management (CM). Its use with criminal justice populations, however, has received virtually no attention.

More than any other single approach for promoting behavior change in substance users, the

efficacy of CM-based approaches has a solid empirical foundation in the experimental literature. For the most part, CM reinforces abstinence from illicit drug use by delivering to study participants cash vouchers, tangible goods, or services contingent upon the delivery of urine samples that test negative for a target drug or set of drugs (e.g., cocaine, opiates). Most of the empirical research on the use of CM techniques among substance-abusing populations has found the approach to be effective at reducing the use of illicit drugs among opiate-addicted individuals (Downey, Helmus, & Schuster, 2000; Higgins, Roll, Wong, Tidey, & Dantona, 1999; Kidorf & Stitzer, 1999; Silverman, Preston, Stitzer, & Schuster, 1999).

An alternative to reinforcing abstinence from drug use is to reinforce pro-social behaviors that are incompatible with illicit drug use. This procedure involves articulating a set of "competing" behaviors that are incompatible with illicit drug use and reinforcing those behaviors. Doing so introduces the new behavior to the individual and increases the frequency of his/her engagement in that behavior. Subsequently, the naturally occurring reinforcing consequences (e.g., improved mental and physical health) are expected to sustain the new behavior after the CM procedure is discontinued. Research that has employed this approach has shown it to be effective (Elk, Mangus, Rhoades, Andres, & Grabowski, 1998; Iguchi et al., 1997; Jones, Haug, Silverman, Stitzer, & Svikis, 2001).

Closely related to reinforcing pro-social behaviors that are incompatible with illicit drug use is the practice of reinforcing treatment attendance and participation. Behavioral reinforcement of treatment attendance was the focus of some early studies using CM in alcohol treatment programs. In general, these studies found that reinforcing attendance increased treatment retention (Gallant et al., 1968), reduced unexplained absences (Ersner-Hershfield, Connors, & Maisto, 1981), and improved employment and social adjustment while decreasing criminal behavior among violent offenders (Funderburk et al., 1993).

Despite their success at reducing illicit drug use within the context of clinically- or community-based drug treatment programs, behavioral reinforcement procedures have been little used with substance-abusing incarcerated populations. A number of studies conducted in the 1970s used behavioral reinforcement techniques in an attempt to improve the management of inmate populations. For example, Bassett et al. (1974) awarded increased telephone privileges to inmates contingent on their attendance at a prison education center and reported subsequent improvement in their academic skills. Ellis (1993) found evidence of the effectiveness of behavioral reinforcement tech-

niques in reducing violent behavior among inmates. However, none of these studies used CM techniques within the context of prison-based programs for substance-abusing inmates.

Most studies testing the effectiveness of CM have been performed in experimental clinical settings and, as mentioned above, reinforce targeted behaviors by delivering to study participants cash vouchers, tangible goods, or services contingent upon their exhibiting the targeted behavior. While proven effective in these experimental settings, the practical application of behavioral reinforcement procedures to real-world treatment settings is less certain. For example, in prison-based treatment environments, care must be taken in selecting the appropriate types of behaviors that are to be targeted for reinforcement. Also, the types of rewards that are used to reinforce targeted behaviors are likely to be different from those normally used in CM studies.

The findings of previous research suggest that an appropriate role for behavioral reinforcement within prison-based substance abuse treatment programs would be to facilitate change in clients' cognitive processes (the goal of most treatment programs) by promoting clients' involvement in the full range of program activities that are designed to effect this change. To that end, behaviors targeted for reinforcement should be those that promote participation and engagement in the treatment process. These might include on-time attendance at required meetings, active participation in group meetings, satisfactory completion of assigned tasks (e.g., writing and essay, making contact with family members), or maintaining proper grooming habits. Such behaviors are likely to require close monitoring as well as objective means of assessing compliance and/or satisfactory completion.

Within the context of a prison-based treatment environment, use of cash vouchers or tangible goods and services to reinforce desired behaviors is likely to be prohibited due to the cost and institutional rules and regulations prohibiting these types of rewards. Transferring this technology to a prison-based treatment setting, therefore, will require treatment staff to develop innovative and less costly ways to reinforce desired behaviors. Examples of rewards that may be used to reinforce targeted behaviors include increased privileges within the TC, additional recreation (yard) time for the inmate, or low cost canteen items or vouchers. Group rewards may include celebratory meals or a movie night in the inmates' housing unit. In addition to being low cost, yet tangible, rewards used to reinforce targeted behaviors should have minimal impact on custody staff time and institutional resources.

## Conclusion

A key characteristic of prison-based substance abuse treatment programs is that they operate *within* rather than *with* larger correctional systems. As such, the organizational culture and climate of the treatment organization often finds itself subordinated to the organizational culture and climate of the correctional system. Criminal justice and treatment agencies possess fundamentally different philosophies regarding drug use and abuse, which form the foundation of their organizational cultures and climates (Prendergast & Burdon, 2001).

Within this organizational reality, efforts to integrate new procedures or treatment protocols into the prison-based treatment environment, such as those discussed above, may be limited by these conflicting philosophies and the dominating influence that the organizational culture and climate of corrections maintains over those of the treatment provider. This is especially true for integrating behavioral reinforcement procedures into a prison-based treatment setting. Rewarding positive behavior conflicts with the underlying notion of prisons as punitive institutions. Many correctional staff may view this practice as rewarding inmates for "doing what they are supposed to do." In addition, institutional policies and the inmate subculture may present additional obstacles. For example, inmates who are not part of the treatment program and thus not eligible for behavioral reinforcement may file grievances based on unequal treatment. Also, certain types of rewards given for engaging in pro-social behaviors (e.g., increased phone privileges, additional trips to the canteen, increased recreation time) may pose logistical and security concerns for custody staff, who must make special accommodations in an otherwise rigid and structured schedule to allow inmates to obtain such rewards.

These and other issues are certain to impact the ability of treatment providers to integrate these new procedures or treatment strategies by presenting a different and more complex set of issues and obstacles than would be the case with community-based treatment programs (i.e., treatment programs that are not subject to the influences of the culture and climate of a larger organization). The contradictory (and often competing) philosophies and goals of the treatment and the criminal justice systems, combined with the relationship that exists between them (as a result of the treatment system having to work within the criminal justice system), shapes the manner in which negative behaviors in the treatment process are sanctioned and the manner in which positive behaviors can be and are reward-

ed. The ability of both treatment and correctional staff to recognize this reality and to mutually commit to engage in collaborative efforts is a necessary first step to overcoming the resulting obstacles to implementing innovative strategies that hold the promise of improving treatment effectiveness while accommodating institutional concerns relating to safety and security.

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