CONTINUITY OF OFFENDER TREATMENT: INSTITUTION TO THE COMMUNITY

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NOTE: Some of the ideas presented in this paper are more thoroughly discussed by the author and others in the forthcoming Center for Substance Abuse Treatment publication Continuity of Offender Treatment from Institution to the Community to be released later this year.

Brief Review of the Literature Leading to the Study of Continuity of Offender Treatment

The effectiveness of jail and prison substance abuse treatment has become well established (Lipton, 1995; Leshner, 1997). Among inmate treatment programs, pre-release therapeutic communities have been the most studied. These programs have a well documented record of success (DeLeon, 1984; Wexler, et. al., 1988; Field, 1989). For example, in the evaluation of the Stay 'N Out therapeutic community Wexler and his colleagues examined the progress of more than 2,000 inmates over a ten year period and found that the therapeutic community was successful with clients with extensive criminal records. Many of these pre-release therapeutic community programs have had active aftercare components (Field, 1989; Chaiken, 1989).

Studies have also shown that community-based offender drug treatment can be successful. National studies (Simpson, 1984; Hubbard, et. al., 1984) have shown that a variety of substance abuse programs are effective with populations that include offenders. Anglin and McGloughlin (1984) present impressive long term follow-up data on the California Civil Addict Program. Treatment Alternatives to Street Crimes (TASC) Programs had more than 40 independent evaluations between 1972 and 1982 demonstrating their effectiveness (Cook and Weinman, 1988). Studies of the TASC programs have particular significance because these programs have focused on transition of offenders from institution to the community.

An important consideration across both institution and community treatment is the growing realization of the role of incentives and sanctions in drug offender treatment and supervision. Once the offender begins drug treatment, his or her reasons for entering treatment seem to have little or no relationship to successful treatment outcome (Leukefeld and Tims, 1988). Therefore, leveraging offenders into treatment increases the numbers of offenders who will benefit from treatment (Anglin and McGloughlin, 1984). Intensive supervision can provide the needed leverage to get offenders into treatment and keep them there (Petersilia, et. al.,1992).

In summary, there are institution pre-release models that work (e.g. - therapeutic communities), and there are community models that work (e. g. - intensive supervision with treatment). However, too little attention has been given to the process of transition from institution to community. Both criminal justice and substance abuse treatment experts have observed that important gains made during incarceration are not being sustained when offenders returned to the community because continuity of care was either inadequate or non-existent (Peters, 1993). According to Peters:

> "Many offenders report feeling overwhelmed by the transition from a highly structured correctional environment to a less structured environment following release. At this time of concentrated stress, an offender enters a culture where little or no support exists - no job, no money, weakened or broken family ties - with immediate needs to plan daily activities, to begin interacting constructively in non-adversarial relationships, and to manage personal or household finances and problems (Peters, 1993, p. 15)."

Authors in related fields of study have made similar observations. The juvenile justice field has been emphasizing the need for aftercare (Altschuler and Armstrong, 1996). The recent and very intensive study of boot camp and shock incarceration programs have begun to emphasize the critical component of aftercare and coordination to aftercare in both theory and research (MacKenzie and Souryal, 1994; MacKenzie and Hebert, 1996).

Recent Studies Showing the Effects of Continuity of Offender Treatment

Only very recently have researchers begun to examine the specific effects of continuity of offender treatment from institution to community on outcome success rates. Inciardi (1996) found that drug-involved offenders who participated in a continuum of drug treatment (prison focused therapeutic community treatment followed by treatment in a work-release center) in the Delaware system had lower rates of drug use and recidivism than the offenders in the institution program alone.

> "The findings indicate that at 18 months after release, drug offenders who received 12-15 months of treatment in prison followed by an additional 6 months of drug treatment and job training were more than twice as likely to be drug-free than offenders who received prison-based treatment alone. Furthermore, offenders who received both forms of treatment were much more likely than offenders who received only prison-based treatment to be arrest-free 18 months after their release (71 percent compared to 48 percent) (Inciardi, 1996, p. 1)."

Wexler (1996) in a similar study in California found that drug-involved offenders who participated in both the Amity prison therapeutic community program and the Amity community-based therapeutic community program on release had substantially reduced rates of recidivism over those offenders that participated in the prison - based program alone. Wexler further presents a data comparison from California, Delaware, and Texas programs showing similar improved outcomes of prison treatment plus continuity into community treatment over prison treatment alone.

Oregon has taken a somewhat different approach. While the prison-based therapeutic community programs in Oregon have always stressed continuity of treatment into the community (Field, 1989), program planners hypothesized that shorter and less intensive prison programs with intensive continuity of treatment into a substantial community program for inmates with lower levels of addiction and criminality would yield similar results to the more intensive therapeutic community programs which were targeted to more criminal and more highly addicted inmates.

In 1990 the Oregon Department of Corrections began a demonstration project to show the effects of a thorough transition program from institution to community treatment. Inmates began a 3 - 6 month pre - release day treatment program in an Oregon prison release facility, and then were followed intensively for 6 - 9 months in community treatment and supervision. Key program elements were as follows:

1. Service providers "reach in" to the institution. Parole and drug treatment services began while the individual was still incarcerated, usually several months before parole. Individual county inmates had their own group led by county drug treatment providers.

2. Joint institution - community release planning. Release center staff developed the inmates' release plan cooperatively with the inmate, the parole officer, and drug treatment

coordinator. Inmates were included in the planning process, and signed an agreement of program participation that included a listing of graduated program incentives and sanctions.

3. Intensive supervision. Once the drug-involved offender paroled, he or she was placed on an intensive supervision caseload in the community.

4. Continuity of treatment. Group treatment continued into the community, usually with the same group leader and with many of the same members of the individual's institution group. Peer support for abstinence and recovery was an important theme of these groups.

5. Careful management of incentives and sanctions. Throughout the process, offenders were provided with incentives for program participation and sanctions for noncompliance or relapse. In the release center, participating inmates were given desirable housing, could earn extra pass time, were provided with special job skills counseling, and were given special consideration for release subsidy funding. They were monitored more closely, including urinalysis, and lost privileges according to a graduated schedule. In the community, program participants also were monitored more closely, experienced graduated sanctions, and were provided the incentives of housing, employment, and other specialized services.

Outcome studies of this program have shown that arrest rates of participating offenders dropped by 54%, and their conviction rates dropped by 65% during the year following treatment (Field and Karecki, 1992). In 1993, three more of these pre-release day treatment programs were begun. The three programs vary in design and population served (one is for woman with young children, one is for male Hispanics who primarily speak Spanish, one is rural), but each emphasizes preparation for community supervision and treatment. A recent study (Finigan, 1996) shows the effectiveness of these programs, including improvement in employment and community adjustment along with decreases in recidivism and community burden.

Theoretical Underpinnings of Continuity of Offender Treatment from Institution to Community.

The reasons for the importance of continuity of treatment from institution to community can be examined from the perspective of the criminal justice system and from the perspective of the individual offender.

From the criminal justice system perspective, the offender is confronted with and by a system that largely isn't a system in the usual sense. Little program coordination exists between arrest, diversion, conviction, probation, revocation, jail, prison, and parole or post prison supervision. While there are examples of excellent coordination to be found between some of these points in the criminal justice system, they are exceptions to the more common phenomena of lack of coordination.

Were an average person to examine a criminal justice flow chart, and be asked where continuity would be the best, that person would probably identify the point of transfer from prison to community supervision. If the offender is under prison supervision and in a prison program, and being sent to community supervision and a community program, what possible excuse is there not to coordinate programs? Given that prison inmates include the most dangerous offenders in the criminal justice system; and given that heavy substance abusing offenders are among the highest risk inmates; and given that considerable societal resources are spent on prison supervision, prison treatment, community supervision and community treatment; shouldn't the public expect efficient and effective coordination of programs from institution to community supervision? Offenders, particularly recidivistic offenders, frequently demonstrate antisocial characteristics. Part of antisocial character includes finding and exploiting any gap in supervision or monitoring. Therefore, the absence of continuity from institution to community programs can be expected to result in an undermining of treatment gains which in turn wastes treatment resources while decreasing community safety.

From the individual offender's perspective, leaving prison, particularly after a lengthy incarceration, can be an intimidating experience. Most people become overly comfortable with highly structured environments: a process called "institutionalization." Individuals with psychological disorders appear to have relatively more difficult readjusting to community living

after living in highly structured environments. This phemenona seems to occur across disorders such as mental illness or addiction, although it may be expressed differently depending on the person and the disorder. Partly because of the disorder itself and partly because of anxiety surrounding the disorder, institutionalized individuals have difficulty transferring learning from one situation to another. What they learn in the institution program does not easily transfer to the community. Institution programs start a recovery process in an environment whose structure helps the change process to begin, and that does not possess a risk to the community. But recovery and self-management skill learning begun in the institution program need reinforcement and some degree of re-learning in the community follow-up program. Without good coordination between the programs; the offender's disorder, anxiety, or both are likely to weaken treatment gains and trigger a relapse. Parole officers have long observed the high-risk status of offenders newly released from prison. As has often been noted in the mental health treatment literature, rather than lament the institution to community transfer of learning problem exhibited by these individuals, we should program to account for it.

Obstacles to Continuity of Offender Treatment

If continuity of offender treatment is necessary and shown to be effective, why does it still only occur by exceptional program, rather than in general practice? Several factors weight against continuity practices. These impediments need to be clearly identified in order to overcome them and move forward.

1. Segmentation of the criminal justice system. The criminal justice system is not a discrete, well-coordinated system, but is actually a cluster of independent agencies and entities with separate justice responsibilities. These entities include jails, prisons, pretrial agencies, probation and parole agencies, the courts, law enforcement, and community organizations working with offenders. Successful transition of offenders into the community requires collaboration among all these entities. However, most of these agencies are under separate funding streams, with differing organizational missions, and they often have little understanding of the other components of the system. (National Task Force on Correctional Substance Abuse

Strategies, 1991).

2. Lack of coordination between the criminal justice system and substance abuse treatment programs. Beyond the discontinuities within the criminal justice system, substance abuse programs most often develop within health or human resource systems that have traditions, values, and goals that are different than the criminal justice system. Bringing these different perspectives together into a common mission can be challenging. Discontinuity occurs more frequently between community treatment and community supervision than it does between the institution treatment and the institution, but the community discontinuity often makes coordination between the institution treatment program and community treatment programs difficult.

3. Loss of post release structure for offenders. Those who have been incarcerated for extended periods of time may be lacking in many basic life skills and the ability to solve day-to-day problems. The decisions about these new obligations can lead to serious consequences, yet often no individual or system is responsible for helping the offender prioritize and balance the challenges of life in the community.

4. Loss of incentives and sanctions at release. Formal incentives and sanctions to participate in treatment and to maintain prosocial behavior may not be as strong in the community as they are in the institution. Without these incentives to continue sobriety and a crime-free life style, offenders struggling with community adjustment may slip into old patterns of behavior. This is particularly true where community supervision has been eliminated, or is not strongly enforced.

5. Lack of services in the community. There are a variety of services needed by the offender in transition. Many of these are considered "ancillary", although without them treatment success is unlikely. For example, an offender will not be able to participate in outpatient treatment if he or she doesn't have housing and transportation. A range of services are necessary for effective treatment.

6. Lack of treatment provider experience with offenders. In some areas community substance abuse treatment providers are inexperienced in adapting substance abuse treatment to people who also bring a history of a criminal lifestyle. Lack of appreciation for the additional problems of criminal thinking and the anxieties surrounding release from incarceration significantly weaken community-based treatment. In a related problem, some community treatment programs fail to recognize the work that has been done in the institution treatment program, serving to further frustrate the offender and increase program dropout.

7. Community funding challenges. The criminal justice population comprises a major percentage of those in need of substance abuse treatment, yet within many community programs there is a lack of specialized staff and few services targeted to meet offenders' needs. This is in part due to the fact that substance abuse treatment agencies have not always identified offenders as a priority population, and agencies that provide community supervision do not always fund treatment services during probation or parole.

Successful Program Models

Strategies for offender treatment continuity from institution to community can be conceptually organized into four types: outreach, reach-in, third party, and mixed program models.

In outreach programs institution staff reach out to community supervision and treatment program providers to ensure continuity. This model is most effective when the case management resources are available within the institution, and when the community services are not sufficiently organized to begin service before the offender leaves prison. An example of an outreach program is The Key program in Delaware where program planners and researchers developed the companion Crest program in the community to meet offender continuity treatment needs (Inciardi, 1996).

Reach-in programs are those where community supervision staff, treatment program staff, or both begin services before the offender leaves prison. This model requires an investment strategy approach by the community agency; seeing the advantage of getting out in

front of problems rather than reacting to problems. Oregon prison therapeutic community and pre-release day treatment programs have employed a number of strategies to build on this continuity of treatment model including program design, interagency agreements, and funding that follows the inmate/offender (Finigan, 1996).

Third party continuity means that an agency separate from corrections or treatment takes primary responsibility for ensuring service continuity. The third party continuity programs are best represented by TASC programs (Weinman, 1992) which are to be found in several jurisdictions. Treatment Alternatives to Street Crimes (TASC) serve as a bridge between the separate systems of criminal justice and substance abuse treatment. According to its written mission and philosophy statement, TASC programs endeavor to both address the justice system's concern for public safety while recognizing the need for community treatment to decrease substance abuse and thereby reduce criminal behavior. TASC participates in justice system processing as early as possible, identifying, assessing, and referring nonviolent offenders to treatment as an alternative or supplement to justice system sanctions. TASC then monitors the offender's compliance with the expectations set for abstinence, employment, and social functioning.

The three program models noted above can be combined in various combinations into mixed continuity models. For example, the Amity program at the Donovan facility in California began as a prison therapeutic community, then developed its own follow-up therapeutic community for prison program graduates (Wexler, 1996).

Summary

Research has shown the effectiveness of both institution and community substance abuse treatment for offenders. However, too little attention has been given to the process of transition from institution to the community. Recent studies demonstrate the added value of good coordination between institution and community supervision and treatment. Theoretical underpinnings, obstacles, and models of continuity of offender substance abuse treatment from institution to community are identified and described.

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