



A MODEL FOR SUCCESSFUL DRUG TREATMENT FROM PRISON TO COMMUNITY

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State and federal criminal justice systems are facing burgeoning prison populations swelled by drug offenders. Mandatory sentences for drug offenders have resulted in an estimated 60 to 80 percent of prison inmates who have substance abuse problems in both state and federal correctional systems. Therefore, it is not surprising that both systems have been working to establish drug treatment programs. Such programs offer special opportunities for both the offender and for the criminal justice system. The circumstances of incarceration actually provide better opportunities for treatment than are usually available in community settings.

Prison is an environment that provides a reasonable likelihood that the client is beyond the need for detox (a situation usually, though not always, true in correctional settings). Prison takes offenders away from most of the immediate opportunities and temptations to relapse, and provides time and opportunity for programming and for contemplating change. As George De Leon (1997; 2000) and others have said, time in treatment is the best predictor of treatment success, and what offenders have is time. Finally, correctional treatment has the potential to offer incentives and consequences, providing more than self-motivation to enter and remain in treatment.

Although a variety of treatment approaches have been implemented with drug-involved criminal justice offenders, the one that has been most used and that has received the most attention from researchers is the therapeutic community (TC), modified for the prison environment (Inciardi, Martin, & Surratt, 2001). This article includes a description and evaluation of such programs that have been implemented in the Delaware correctional system, and that have achieved significant national attention and evidence of long-term success (Butzin, Martin & Inciardi, 2005; and Inciardi, Martin & Butzin, 2004.)

Therapeutic communities in corrections

Drug abuse researchers and practitioners have consistently found that the "TC" is the most effective treatment for drug-involved offenders, particularly for prisoners who are going to be released back to the community (Leukefeld & Tims, 1992; Inciardi, Martin & Surratt, 2001). Drug-involved offenders who come to the attention of state and federal prison systems are typically those with long arrest histories and patterns of chronic substance abuse, and the intensive nature of the TC regimen tends to be best suited for their long-term treatment needs (De Leon, 2000). Moreover, the TC works especially

well in a correctional institution because it is a total treatment environment isolated from the rest of the prison population — separated from the drugs, the violence, and other aspects of prison life that tend to militate against rehabilitation. The primary clinical staff members in such programs are typically former substance abusers who themselves underwent treatment in therapeutic communities. The treatment perspective in the TC is that drug abuse is a disorder of the whole person; that the problem is the *person* and not the drug; that addiction is a *symptom* and not the essence of the disorder; and that the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use (De Leon, 1997; 2000).

A multi-stage therapeutic community treatment continuum

Clinical and research experiences with correctional systems and populations support the use of a staged therapeutic community treatment intervention (Brown, 1979; Ball & Ross, 1991; Inciardi, Martin & Surratt, 2001; Beard & O’Connell, 2005). Each stage in this treatment continuum is matched to the client’s changing correctional status: incarceration, work release, and parole (or other form of community supervision). This approach recognizes that “the connection between rehabilitation efforts in prison and the process of integration into society after release is probably one of the most feeble links in the criminal justice system” (Wexler & Williams, 1986).

The primary stage of treatment should consist of a prison-based TC (Inciardi, Martin & Surratt, 2001). Segregated from the negativity of the

prison culture, recovery from drug abuse and the development of pro-social values in the prison TC involves essentially the same mechanisms seen in community-based TCs (De Leon, 1997; Martin et al., 1995). Therapy in this stage is an ongoing and evolving process over 12 months, with the potential for the resident to remain slightly longer, if needed. Moreover, it is important that TC treatment for inmates begin while they are still in the institution.

In a prison situation, time is a resource that most inmates have in abundance. The competing demands of family, work, and the neighborhood peer groups are absent. Thus, there is the time and opportunity for focused and comprehensive treatment, perhaps for the first time in a drug offender’s career. In addition, there are other new opportunities presented: to interact with “recovering addict” role models; to acquire pro-social values and a positive work ethic; and to initiate a process of understanding the addiction cycle.

The secondary stage of treatment should be a “transitional” TC in a work release setting (Inciardi, Lockwood & Martin, 1994). Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration, where inmates approaching their release dates are permitted to work for pay in the free community, but must spend their non-working hours in a correctional work release facility. Graduated release of this sort should facilitate an inmate’s process of community reintegration. But there is a potential negative side, especially for those whose drug involvement served as the gateway to prison in the first place. Inmates are exposed to groups

and behaviors that can easily lead them back to substance abuse, criminal activities, and reincarceration. Since work release populations mirror the institutional populations from which they came, they still harbor the negative values of the prison culture, and street drugs are available and street norms abound. As such, there is even more need for the TC in transitional work release than in prison. The clinical regimen in the work release TC must provide intensive therapeutic community treatment, and also assist the inmate in returning home and obtaining employment.

“The Therapeutic Community is a dress rehearsal for right living within the microcosm of the correctional treatment environment, thereby setting the stage for a more productive and manageable offender during their incarceration. It also remains indisputable that this rehearsal is merely a precursor to the real life experience of the offender’s inevitable role as a member within a new community.” — Comment from a Delaware Work Release Treatment Counselor

In the tertiary stage (aftercare), clients will have completed work release and will be living in the community under the supervision of parole or some other supervisory program. For those individuals who entered work release after serving mandatory fixed sentences, there is no parole requirement, and hence, no community supervision. Treatment intervention in this stage involves outpatient counseling and group therapy. Clients are encouraged to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, to call on their counselors on a regular basis, and to spend one day each month at the facility.

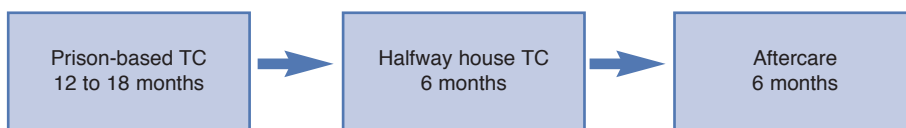


FIGURE 1. THERAPEUTIC COMMUNITY CONTINUUM OF CARE

A phased system of correctional treatment in Delaware

TC treatment within the Delaware system occurs at the three levels corresponding to the client's status in the correctional system: TC treatment within prison; TC treatment during work release; and a TC aftercare program during subsequent community probation (see Figure 1). Within prison, TC treatment (the KEY Program) occurs in a separate and isolated unit of the facility for the 12-month period corresponding to the last year in prison. Next, during the six-month work release commitment required of most releasees, the TC program (CREST) takes place in a separate halfway house correctional facility adjacent to the regular work release facility. Finally, an aftercare program for graduates of the work release program consists of weekly outpatient group meetings and one day each month at the facility for the first six months of subsequent community supervision. (Although corrections often uses the term 'aftercare' for any treatment after prison, here, it specifically refers to a continuing care program, following TC principles, that occurs after work release) (Beard & O'Connell, 2005).

Both the work release CREST TC and the KEY TC within prison are organized similarly to the traditional therapeutic community, with a "family setting" removed from many of the external negative influences of the street and inmate cultures, replaced by the TC "right living" principles. The primary concepts concerning TCs are based on self-help, shared responsibility, peer influence, and community as method. Although the TCs use professional personnel as well, recovering staff members and the other clients are regarded as critical sources for help within the therapeutic environment. The continuing emphasis on principles and practices of right living that characterize TC environments serve as constant

reminders to graduates to pull-up (be aware and get a grip) on their previous and current negative behaviors.

"Clients are often exposed to the same environments and issues that led to their incarceration. They are often overwhelmed with the responsibility of children and family members who may or may not be supportive; that expect them to just get their life together and "make up" for prior acts. Without a support network and a place to come and discuss these issues and find solutions that include making short-term goals, they are often lost and confused." — Comment from Delaware Aftercare Counselor

The CREST TC treatment program during work release has been the centerpiece of the phased treatment system (Hooper, Lockwood & Inciardi, 1993). Work release is a form of partial incarceration whereby inmates who are approaching their release dates are permitted to work for pay in the free community, but must spend their non-working hours in a secure work release facility. The clinical regimen in the work release program is modified to address security concerns and the correctional mandate of work release to prepare clients for employment in the community (De Leon, 1997). Both the regular work release and the work release TC are six-month programs. During the first three months, the TC participants, as opposed to those in regular work release, are not allowed to go out to work. Some of the CREST participants have previously participated in the prison KEY program, but for most, the work release treatment is their introduction to treatment within the correctional system.

Aftercare generally follows the same guidelines as most outpatient counseling approaches: individual counseling, group counseling and graduated sanctions for relapsed clients. However,

there is an enhanced focus on transitional issues, providing a continuum of care, while maintaining a familial connection between aftercare participants and CREST TC participants; and providing case-management services through the coordinated efforts of probation and parole officers and treatment personnel. The TC healing environment, pro-social approach, goal-directed terminology, and familial connection between residents cultivate a brother/sisterhood that fosters genuine concern and on-going support that continues well after graduation from the program. A particular benefit to aftercare participants is that they attend sessions at the CREST TC with their treatment family members in a physically and psychologically safe place.

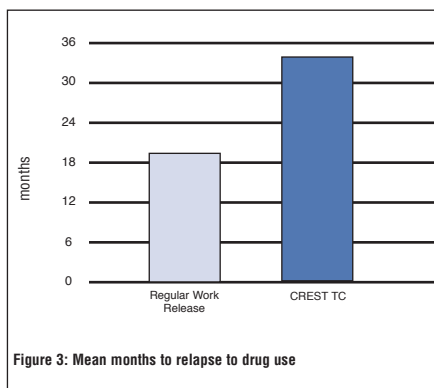
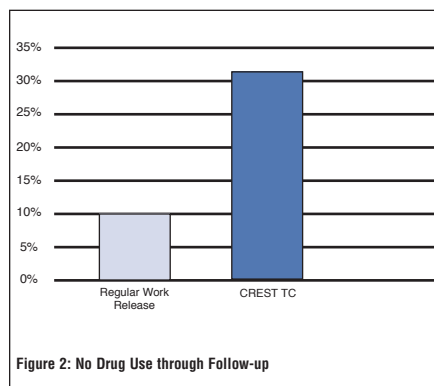
Study of treatment effectiveness

The research evaluation of the Delaware TC programs examined inmates who were released through most of the 1990s. A sample was drawn from those classified in the Delaware correctional system as approved for work release with a recommendation for drug treatment between 1991 and 1998. Because the number of those so classified exceeded the capacity of the treatment programs during that period, those eligible were assigned to either treatment, or to regular work release, a "no-treatment" group.

We interviewed more than 1,200 of those work release participants — roughly 300 who were in regular work release and 900 who had participated in the treatment program — at least one year after the end of work release. Nearly 70 percent were contacted again and re-interviewed five years after their release. We asked about their drug use, as well as their criminal behavior, employment, and a range of other behaviors. Urinalysis tests also were conducted at the time of each interview. The group was largely male (80 percent) and African-American (78

percent), with an average age of 30. Participants had extensive criminal histories, with an average of nine arrests and four incarcerations. About 40 percent were unemployed prior to this incarceration, and only about 30 percent were, or ever had been married.

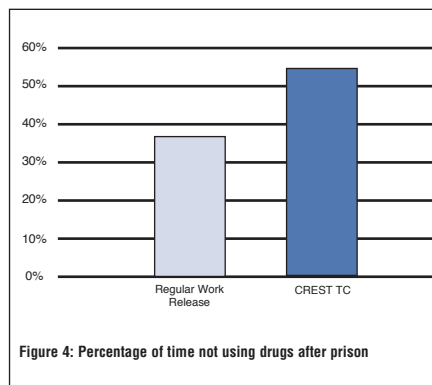
Relapse was defined as the report of any use of an illicit drug over the five-year period, or any positive urinalysis. Results for relapse are shown below in Figures 2 and 3. These analyses controlled for other background variables (see Inciardi, Martin & Butzin, 2004; Butzin, Martin & Inciardi, 2005). For those individuals with at least one year of follow-up, abstinence rates were 32 percent in the treatment group and 10 percent in the no-treatment group. Time to relapse was a mean of 29 months in the treatment group versus 13 months in the no-treatment group. Even those who did not complete treatment were significantly more likely to have remained abstinent than those without treatment.



The treatment group also showed significantly less time in periods of drug use. As shown in Figure 4, regard-

less of whether or not they had had relapsed at any time during the follow-up period, the treatment group had a significantly higher proportion of their time abstinent from drug use (53 percent), than did the no-treatment group (38 percent). Moreover, the treatment group had a significantly higher rate of employment after leaving work release (55 percent) than did the no-treatment group (45 percent).

When defined as any use of an ille-



gal drug, relapse is a very stringent criterion of treatment effectiveness. Even a single incident of drug use counts against program effectiveness. Further analysis was conducted with a definition of relapse as frequent drug use, defined as the report of at least weekly drug use. The pattern of significance was the same for this analysis, with 50 percent of the treatment group evidencing no, or infrequent drug use compared to 28 percent of the no-treatment group.

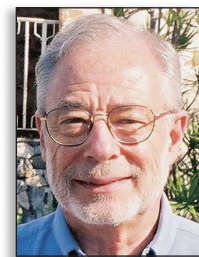
We statistically controlled for other differences that might have explained the differences between the groups, but participating in the work release treatment program still cut the odds of relapsing in half. As one would expect, older participants and those employed were significantly less likely to relapse. None of the other variables examined, including participation in treatment programs within prison or participation in treatment programs before incarceration, predicted subsequent drug use.

Conclusion

Employing a TC program at the point of transition between prison and community has significant benefits that are long lasting. In our study, the proportion of those treated who remained abstinent was approximately three times that for those without treatment. For those who received treatment, the time to relapse was approximately twice as long as for those who did not receive treatment. Finally, total time abstinent for those in treatment was about one-third longer than for those not receiving treatment.

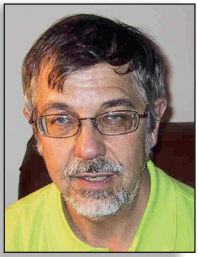
In contrast, treatment within prison alone had a much smaller impact on outcomes. Treatment while in prison had a significant effect only upon the overall time spent using drugs after prison, but not on the rate of abstinence or the time to relapse.

It appears that the superior impact of CREST TC treatment in the transitional period is due to providing support when risks of returning to previous behaviors are much stronger. The development of an environment and community of peers that both demands and supports the individual taking responsibility for pro-social behaviors appears significant, if not critical, to the transition from institution to community. The individual going it alone in reintegrating into the community is at a decided disadvantage to his or her peer who can draw on the strength and support of a transitional program to resist the persistent pressures to lapse again into a debilitating pattern of drug use. ☉



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