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Clinical Utility and Policy Implications of a
Statewide Community Corrections Treatment Process

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Abstract

This paper examined the literature on community-based corrections programs and the utility of assessment and treatment of adult offenders with substance use disorders who approach release from the prison stay. A review of a multi-stage approach to substance abuse treatment, specific treatment modalities and aftercare interventions and recidivism trends comprise the literature review. This article also examined the viability of linkage between the institutional substance abuse treatment programs and the community-based intervention options (i.e., Community Education Center's Model). Adult offenders who receive a combination of in-prison treatment, transitional treatment and community-based aftercare treatment tend to be more successful in their behavioral outcomes than those who have little or no treatment interventions. A promising statewide community corrections model that integrates the best practices literature is described.

Key Words: community corrections, reintegration, transition, aftercare, substance abusing offenders, multi-stage approach

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Introduction

The magnitude of criminal behavior in the United States, rooted in drug related offenses, is alarming. In an effort to establish the causal factors for drug related offenses, its economic impact, and the development of corrective strategies, numerous researchers and law enforcement practitioners have joined forces. Their efforts are reflected in the works of the various agencies at the federal and state levels of government (i.e., Bureau of Justice Statistics (BJS) 1998, 2000, Congressional Black Caucus, National Institute of Drug Abuse (NIDA), etc.). These agencies have conducted research on the treatment, rehabilitation, and reintegration of substance use offenders and recidivism in criminal behaviors (Altschuler, and Armstrong, 1998; Catalano, Wells, Jensen & Hawkins, 1989; Feldkamp, 1995; Field, 1985; Hiller, Knight & Simpson, 1999; DeLeon, 1994). The relation between criminal activities and substance use in many cases underscores a stabilized acceptance of this negative behavior in society, (BJS, 1998). This relationship continues to show increasing trends.

Drugs and crime are interrelated and this relationship has been well documented (Inciardi & Martin, 1997; Hiller, et al., 1997). The increasing number of offenders, coupled with limited diversion, institutional and community-based programs, and reduced rehabilitation emphasis, compels “warehousing” offenders as the option of choice (Inciardi & Martin, 1997; Altschuler & Armstrong, 1998) versus effective preventive and tertiary interventions. Society is steadily challenged to absorb the costs imposed by criminal activity and an expanding prison population brought on by the warehousing option. It is readily apparent that in order to disrupt this negative progression, significant actions must be taken to proactively enforce effective community-based programs at all points along the criminal justice continuum (Chaiken & Chaiken, 1990; Inciardi & Martin, 1997; Inciardi & Pottегier, 1998; French et al., 2000 and Terry-McElrath et al., 2002).

Unless continued institutionalization of offenders can be shown to improve current abilities to protect the community once released back into the community, in effect, public safety is jeopardized (Altschuler & Armstrong, 1997). There is, however, a growing consensus among corrections professionals and researchers that in order to ensure public safety and reduce recidivism of those incarcerated offenders most likely to re-offend once released, a critical need exists for some offenders to receive more than retribution and incarceration. Rather, what is needed is a reintegrative-oriented process that begins with incarceration for intervention services. This process should be directed towards an established alliance that links institutional and community corrections. There must be a viable effort to approach this dilemma from a different perspective.

Community corrections, in this context, refers to an alternative to incarceration such as residential centers, halfway houses, work furloughs, probation, parole and other programs designed to manage offenders in the community (Petersilia, 1993). From the 1980's onward, there has been a significant growth in community corrections programs. Seventy-five percent of offenders under correctional supervision are involved in community corrections programs (Petersilia, 1993). Nonetheless, community corrections programs have been faced with definitional and purpose issues. Specifically, the goals, and mission of community corrections programs have been confusing, leaving many to question its utility. As DiIulio (1991) notes,

“Most Americans think that criminal sanctions that make little or no use of incarceration fail to protect the public adequately, to deter would-be criminals, and to prevent convicted offenders from finding new victims. Furthermore, they simply do not feel that alternatives to incarceration are an adequate moral response to the pain and suffering imposed upon innocent victims by often calculating and remorseless victimizers” (p. 68).

Hence, two significant problems face community corrections programs need to be addressed: the primary mission of community corrections programs and the lack of research to support these programs (Petersilia and Turner, 1993). Nonetheless, there remains optimism about community corrections and as a result, many states have expanded its community corrections services.

In debates pertaining to the effectiveness of community-based programs, many policy makers have argued that the criminal justice system must simultaneously balance three major goals: (1) ensure public community safety, (2) hold offenders accountable for their actions, and (3) provide an environment in which offenders can develop into capable, productive, and responsible citizens (Altschuler & Armstrong, 1998; Terry-McElrath et al., 2000). This is only a small portion of the program goals that would adequately and appropriately accomplish reinforced public community safety. Equal attention must be paid to the reinforcement of all prior treatment received in an institutional setting as the community-based service delivery is refined (Castellano, 1995; Altschuler & Armstrong, 1998; Altschuler & Armstrong, 2002). This requires specific examination of multistage substance use treatment programs for offenders and the corresponding reduction of recidivism.

The purpose of this paper is to examine the existing literature regarding the viability of community corrections programs with substance abuse offenders who are approaching release and their impact on the reduction of recidivism. The following concepts underscore the literature review: (1) previous studies on juvenile and adult justice community corrections programs, (2) assessment of the most productive theoretical model for intervention and strategies that serve as links between institutional-based and community-based treatment and their impact on the individual's post-release reintegration, (3) integrity (i.e., validity and reliability) of institutional treatment processes. The defined variables pertinent to this discussion will be the impact that

effective community-based corrections programs have on the rate of both the success of rehabilitation/recovery and reduction in recidivism/criminality of substance abuse offenders, and (4) assessment of multi-stage approaches with specific focus on aftercare and recidivism trends. Additionally, the literature review addresses the viability of linkage between the institutional substance abuse treatment programming and the community-based aftercare intervention options (i.e., Community Education Center's Model).

Previous Studies on Juvenile and Adult Offenders

The statistical data collected by BJS (1998, 2000) show that there are growing concerns for the population of juveniles committing drug related offenses and their maturation into adult offenders. This concern and the well-documented (Altschuler & Martin, 1998; Hiller et al, 1999) occurrences of these criminal behaviors have prompted greater attention to the preventive nature of recidivism. These reiterate the commonality of the linkages between In-Prison Treatment Communities (ITC), Transition Therapeutic Communities (TTC) and Community-based Aftercare (CA) treatment programming (DeLeon, 1994, Feldkamp, 1995 and Terry-McElrath, et al., 2002). Prevailing research notes that without effective and reinforced intensive supervision, casemanagement and individual behavioral modification, any attempts at lifestyle change will be unattainable (Hassin, 1996; Altschuler & Armstrong, 1998). Altschuler & Armstrong (1997) say “There is increasing agreement, in principle, that incarceration lacking treatment, on the one hand, and more generally that social control and treatment without a close, working collaboration that integrates and links institutional corrections, aftercare, community service providers, and social networks on the other hand is a prescription for failure” (p. 76).

Studies show preventative approaches in juvenile/adults drug-related criminal behaviors are most effective when combined with treatment interventions that include the following elements: (1) treatment modalities that foster long-standing sobriety, (2) teaching appropriate decision-making, and (3) maintaining a commitment to societal integration (Field, 1985; Feldkamp, 1995; Peters, Strozier, Murrin, & Kearns, 1997). The overlapping issue remains the balance between individual recovery/rehabilitation and public community safety. Little will be gained in achieving this balance if serious efforts within the institutional-based and community-based corrections programs are not in complete agreement (Castellano, 1995; Altschuler & Armstrong, 2002).

As the viability of preventive strategies emerges in juvenile/adults drug-related criminal behaviors, it is the combination of the aforementioned elements that foster long-standing sobriety, appropriate decision-making, and a commitment to societal integration that may product more positive outcomes (Field, 1985; Feldkamp, 1995; Peters et al, 1997). Again, the overlapping issue remains the balance between individual recovery/rehabilitation and public community safety (Castellano, 1995; Altschuler & Armstrong, 2002). As highlighted by Altschuler and Armstrong (2002), “In short, the intent is to have community-based aftercare services parallel those that are first initiated in the institution, and to have institutional services geared to achieve essentially the same purposes as those which will be provided in the community” (p. 120). The integrity of the treatment design in ITC/TTC is a consistent factor in capturing the attention of both the juvenile and adult offender (Feldkamp, 1995). By following through with intensive supervised CA the product of the treatment modalities are reinforced and stabilized (Castellano, 1995; Hiller, et al, 1999; Terry-McElrath, 2002).

Multi-Stage Theoretical Models

Feldkamp (1995) notes that most substance abusers involved in corrections require a multistage approach in treatment modalities in order to maintain long-term stability. Research clearly indicates in every assessment of treatment modalities ranging from the ITC/TTC to the CA treatment interventions, two factors are significant: (1) the intensity of supervision and (2) the degree of individual internalization (Feldkamp, 1995; Hiller, et al, 1999). Bearing this in mind, the most effective approaches in treatment modalities focus on the intensity of cognitive behavioral modification and social learning strategies in the administration and operation of their model's design (DeLeon, 1994; Inciardi & Martin, 1997). While ITC/TTCs focus on a "relatively" short-term duration (i.e., duration of sentence), long-term gain in the stability of the modifications to the individual's belief systems and decision-making abilities are maximized in the intense aftercare (CA) design (Peters et al, 1997). Therefore there must be an appropriate balance between the aims of ITC/TTC and CA programming. Field's (1985) work in the Cornerstone Program Study underscores the significance of having an initially intensive short-term program of psychoeducational/addiction awareness followed by a structured and demanding aftercare reinforcement program through proactive community-based correction's case management parole-probation's supervision. As this is accomplished, the rapport and dialogue established between case manager and substance abuser reinforces a sense of ownership and empowerment. Ownership and empowerment are essential to the substance abuser's community reintegration. As a by product of the interaction between the casemanager and substance abuser, a foundation of productive citizenship is established.

The balance in multistage ITC/TTC and CA programming is the most effective linkage to reductions in post-release recidivism rates (Field, 1985; Inciardi & Martin, 1997). As Field

(1995) notes, “In addition to prison-based treatment, residential aftercare is important for seeing improved post-prison outcomes” (p. 37). Hawkins and Catalano (1985) conducted a study of aftercare in drug abuse treatment. Their results show prison-based treatment (ITC) lowers the risk of rearrest after release and prolongs the length of time until rearrest occurs, especially when followed by residential community based aftercare. That is, when compared to the untreated and ITC treatment groups, parolees who completed both the ITC and TTC were not only least likely to be rearrested upon release from prison, but were also likely to have the longest elapsed time before being rearrested. This study represents a first stage examination of the impact of residential aftercare on recidivism. In conclusion, their study suggests two implications for implementing an effective multistage model for the care continuum. That is, an intensive in-prison model of behavioral modification and addiction education reinforced by a proactive and committed aftercare system in community-based corrections. Only by providing quality aftercare will the impact of the integration of the post-release offender into society be maximized.

Multi-Stage Substance Abuse Treatment Interventions

The current history of both the institutional-based and community-based corrections as it pertains to substance abuse offenders indicates strong attention is paid to three distinct phases of treatment approaches (Field, 1985; Feldkamp, 1995; Altschuler & Armstrong, 2002). As previously indicated, these phases of treatment interventions include: (1) In-prison Therapeutic Communities (ITC), (2) Transition Therapeutic Communities (TTC), and (3) Community-based Aftercare (CA) (De Leon, 1994; Feldkamp, 1995; Terry-McElrath et al, 2002). These approaches serve as the links between offenders’ cognitive behavioral modification and their tendency to return to criminal behavior (i.e., recidivism). The general hypothesis is drug-

involved offenders who receive a combination of primary treatment in an ITC followed by TTC and reinforced by a CA will be more successful in their behavioral outcomes than those who have little or no treatment interventions (Inciardi & Martin, 1997). As noted by Altschuler and Armstrong (1998), “Research findings suggest that either better outcomes are apparent or the potential for positive results increases when there is a highly structured and enhanced transition from correctional facilities into the community” (p. 118). Additionally, efficacy in behavior modification pertaining to substance abusers, requires the integration, mobilization, and implementation of community-based resources that facilitate and reinforce the ITC/TTC interventions (Terry-McElrath et al, 2002).

As noted earlier, the common thread tying these interventions is strengthened by three factors: (1) the integrity (i.e., validity and reliability) of the institutional treatment processes design; (2) the substance abuser developing a sense of ownership and accountability that reinforces treatment received while in the ITC/TTC; and (3) the assessment of the most productive theoretical model for intervention and strategies serve as linkage between ITC/TTC and CA treatment and their impact on the individual’s post-release reintegration (Field, 1985; De Leon, 1991; Hassin, 1996). Simply stated, the gains in an intensive in-prison therapeutic community must be reinforced proactively in the receiving community if a therapeutic change is to occur. Inciardi and Martin’s (1997) study of the Delaware correctional system’s multistage treatment community systems clearly identify these factors as the central issues for an effective model that enhances appropriate decision-making. In summary, findings clearly demonstrate there is a significant viability for implementation of this approach in both juvenile and adult substance abuse offender populations (Hassin, 1996; Inciardi & Martin, 1997, Terry-McElrath et al, 2002).

Assessment of Multi-Stage Approaches

Current research supports the relationship between intensive ITC/TTC and CA in successful long-term recovery agenda and recidivism reduction (Hawkins & Catalano, 1985; Catalano et. al., 1989; and Hassin, 1996). Studies show that individuals who consistently reinforce the behavioral gains of ITC/TTC and internalize application process are more proactive in their decision-making in diverse societal encounters (De Leon, 1991; Hiller et al., 1999). Given the primary objective of community-based corrections, to ensure the public community's safety, the evaluation and implementation of global CA interventions becomes increasingly imperative. Central to this evaluation process is the role that the reinforced applications of social learning and individual thought processes play in shaping substance abuser offender's lifestyle changes (Hawkins & Catalano, 1985; Hiller et al., 1999). This enhances their reentry into society.

Increasingly, the literature notes the sense of ownership fostered by appropriate integration of ITP/TTC and CA in shaping the attitudes of post-released substance abuse offenders. Cognitive Thought Process (CTP) is an interactive cognitive developmental process that significantly contributes to five skills essential to socialization, learned compatibility, knowledge management, and leadership application: symbolization, vicarious learning, self-regulation, self-efficacy, and their ability to see the future consequences of present behaviors. Concurrently, individual core values and ethics calibrate their moral compass (Catalano et al., 1989; Hiller et al., 1999; Altschuler & Armstrong, 2002). Cognitive Thought Processes' integration of core values, beliefs, and ethics, coupled with observational learning, retention, and motivation, enable individuals to become more adapt at defining their expressed behaviors. Values and ethics are essential to both the interpretative decision-making process and conflict resolution as opposed to criminal thinking behaviors (De Leon, 1991; Feldkamp, 1995; Inciardi

& Martin, 1997). Cognitive Thought Process and perceptive awareness are central components in the construction of the model of CA interventions. This is the emergent key component in recidivistic behavioral reductions—cognitively breaking the cycle that limits self-integration (Catalano et al., 1989; Inciardi & Martin, 1997; Terry-McElrath et al., 2002). The emergence of self-integration is a core element sought after in measurements of aftercare efficacy in recidivism reduction (Inciardi & Martin, 1997; Inciardi et al., 2000; Terry-McElrath et al., 2002). As noted by Inciardi et al., (2000), “Aftercare programs appear to provide a critical bridge between institutional confinement and community reentry by providing assistance for the psychological, social, and legal obstacles that can place drug-involved offenders at risk for relapse and recidivism during work release and parole.” (p. 216).

Towards an Effective Intervention Strategy

The multistage substance abuse treatment model is the most effective intervention strategy in the reduction of drug related crime (Catalano et al., 1989; Inciardi & Martin, 1997; Terry-McElrath et al., 2002). This model must foster an appropriate balance between In-Prison Therapeutic Communities (ITC) and Transitional Therapeutic Communities (TTC), coupled with Community Aftercare (CA) which is proportionally related to post-release substance abusers reduction in criminality and recidivism (De Leon, 1991; Feldkamp, 1995; Inciardi & Martin, 1997). The key components of this model must be: (1) In-prison Therapeutic Community - a multistage intervention substance abuse treatment program based on the concepts of family, theory, approaches, and integration. The central objective is psychoeducational determination of cognitive behavioral processes and addiction awareness. Duration of treatment is related to 18 – 36 months of an individual’s period of incarceration. This training is normally conducted in three phases (i.e., orientation, indoctrination, transition), (2) Transitional Therapeutic

Communities—is a follow-on to phase reinforcement to the ITC model of substance abuse treatment. The Transitional Therapeutic Communities phase is primarily conducted in a halfway house/transition facility that offers work release, educational/vocational training, and family integration to its population. The two phases of reinforced treatment offered are: integration into the community and positive lifestyle decision-making methods. The length of this treatment is appropriately 6-9 months, and (3) Community Aftercare – is community corrections based intensive effort to reinforce the prior psychoeducational and socialization training received in the ITC/TTC phases of substance abuse treatment methods. Corrections-based authorities in conjunction with private, Federal and state counselors and placement officials administer and supervise this program. The duration of the intervention is ongoing and consistent with the requirements of post-release supervision and case management. The multistage substance abuse treatment model that effectively balances these components will have the greatest degree of success reducing recidivism.

Implementation of a Statewide Community Corrections Model

The implementation of a statewide community corrections substance abuse assessment and treatment process requires a clinical model of care that provides an unbiased estimate of the need for further assessment and treatment across a wide expanse of variables. According to Petersilia, 1993, the mission of community corrections should be to:

“Assist the court and/or parole board in assessing candidates’ suitability for community placement; and once offenders are placed in the community, to enforce the court-ordered sanctions, protect the community, assist offenders to change and support the rights of their victims.” (p. 79).

Additionally, these variables should include ethnicity. African-American, Hispanic and Native-American adults, who are overrepresented in the criminal justice settings and underrepresented in substance abuse treatment, are at risk of being overlooked by professional assessment, treatment methods and policies. The clinical model used in a statewide assessment and treatment model should take this risk into consideration. A statewide assessment and treatment model should capture cultural differences and discriminate between behaviors and symptoms requiring specialized treatment.

The design and impact of various statewide assessment and treatment methodologies has been the subject of intense study over recent years (Hiller, et al., 1999; Altschuler & Armstrong, 2002 and Terry-McElrath, et. al., 2002). Research in these methodologies has led to the development of the Responsivity Principle. This principle asserts that particular individual characteristics affect how each person will respond to treatment (Latessa, Cullen & Gendreau, 2002). To be effective, community corrections programs must take the following program guidelines into consideration:

1. Treatment is offered in a concrete cognitive framework.
2. Treatment is delivered by trained, certified, clinically supervised staff.
3. Treatment addresses criminogenic factors.
4. All staff members are expected to be enthusiastic and engaging and able to handle their authority without domination and/or abuse.
5. Staff members are trained to recognize antisocial thinking, feeling and acting and are able to suggest, demonstrate and reinforce concrete alternatives.
6. Structured, on-going follow-up.

According to Persilia, 1993, community corrections models should rely on at least four indicators. First, community corrections programs should openly articulate the organization's goals, mission, and treatment philosophy. For example, emphasis might be placed on assessment and referral or long term treatment. Second, community corrections programs should clearly indicate the specific goals and objectives of the program. The goals and objectives should describe specific interventions and strategies in accomplishing the goals and objectives. Third, these programs should specify methods and activities that address each goal. Fourth, these programs should specify performance indicators. Performance indicators should reflect the organization's values and long-term improvement plans.

A statewide community corrections model must involve assessment, individual contact, group interventions, experiential workshops and lectures as part of the treatment curriculum. Throughout the treatment process, offenders should be monitored for behavioral problems and should be subject to frequent random testing for alcohol and drug use. The treatment progress of offenders should be managed and monitored by a team of professionals, including educators, certified alcohol and drug counselors, vocational specialists, and medical professionals. Regular treatment team meetings should be held to review cases and monitor behaviors in all facets of the program. Progress in the program should be based upon performance and behavior. The development and maintenance of favorable attitudes, associations, and skills should promote rewards and the reduction of costs to the individual. Concrete alternatives to anti-social styles of thinking, feeling, and acting should be introduced and reinforced. The group counseling program should be presented in a standardized manner, relying upon curricula. This clearly is in keeping with the common factors of program effectiveness that measure the viability of ITC/TTC and CA interventions.

One such community-corrections intervention model that achieves this emphasis on the appropriate balance between individual recovery/decision-making viability and public community safety (i.e., recidivism rate reductions) is the Community Education Centers (CEC) program of treatment and education services. The following section describes the CEC model and its statewide implications.

Overview of the CEC Model

In 1994, the State of New Jersey Department of Corrections (NJDOC), in collaboration with the CEC, implemented a statewide community corrections substance abuse assessment and treatment process for adult inmates served by the State of New Jersey's Department of Corrections. Community Education Centers has worked in partnership with the NJDOC and other government agencies to provide intensive treatment and educational programs that focus on changing addictive and criminal behaviors, preparing residents for community reintegration, and ultimately reducing recidivism. The services are designed to be residential in nature, short term (assessment, treatment and referral) and transitional (half-way houses, work release), having an impact on the growing prison population, and providing effective services to reduce recidivism. The CEC program complements the structure of the NJDOC's multi-stage approach to treatment. The New Jersey DOC provides the first segment of the continuum of institutional substance abuse services followed by the CEC community substance use services. These services include the following: residential assessment, treatment and referral, halfway houses, work release, day reporting, and aftercare (electronic programs, etc.).

Insert Table 1 Here

The CEC model is designed to serve the needs of offenders who approach discharge with 18 months or less before their first parole hearing.

All CEC programs are designed to meet the needs of the referral agency, community and the needs of the offenders with concentration on alcohol and drug treatment, life skills training, and educational and vocational instruction. Two elements that all the programs have in common are rehabilitation and a safe environment. No matter what the special focus of the facility, each program provides each participant, with rehabilitative case management specific to that individual's needs, in a safe and secure environment. The CEC model takes into consideration that the substance abusing offender population presents unique challenges with regard to the treatment and custody. Therefore, although CEC is responsible for the custody, care and treatment of individuals who are the subject of the programs, all admission and discharge decisions are made by the New Jersey Department of Corrections.

Security and treatment go "hand in hand" at CEC facilities. It is when residents comply with facility rules that effective treatment is possible. Therefore, security considerations are of utmost importance to the operations of the programs. Community Education Center employs experienced correctional and treatment supervisors, many of whom have had experience in large secure government correctional institutions, to oversee security operations. Community safety takes precedence over all other considerations and is ultimately in the best interests of offenders and their families. Although CEC's community-based corrections programs do not treat residents as prisoners, the facilities are totally secure in order for treatment to be effective. The marriage of correctional and clinical knowledge is an essential foundation for successful treatment of the offender population.

Clinical services at the facilities are provided by a multidisciplinary team including physicians, psychologists, nurses, counselors, certified addictions counselors, case managers and social workers. These and other CEC staff members provide a wide variety of assessment, treatment and health-related services to residents, including those offenders with co-occurring mental disorders and substance use problems. Treatment interventions are based upon a set of assumptions that reflect the most current thinking in the field, including establishing accountability to accept responsibility. The reduction of denial and minimization as well as the development of victim empathy are considered cornerstones in developing motivation for behavioral change.

Community re-integration and aftercare planning are based in risk management practices that decrease opportunities and capacities for offenders to re-offend. Further, the CEC model recognizes and understands that the community is viewed as the primary client of treatment. Therefore, ensuring public safety and victim protection are the fundamental goals of the programs. CEC has the experience and technology to provide Global Positioning Systems (GPS), as part of its outpatient services.

The CEC Continuum of Services

The CEC Continuum of services relies upon a wide range of treatment programs and interventions. The treatment programs combines features of cognitive-behavioral therapy, primarily Rational Emotive Behavior Therapy (REBT), a cognitive-behavioral form of intervention; the principles of AA and NA and Reality Therapy (Fretz, 2002). Because the multi-stage treatment approach is a recognized model for offenders with substance use histories, CEC embraces its principles. One reason for its recognition is that it not only provides a specialized treatment approach, but also addresses the external dimension of supervision and

management. Throughout institutional treatment, the multi-stage treatment model provides opportunities for offenders to identify specific triggers, high-risk situations and precursors to offender behaviors unique to each offender. Oftentimes, these warning signs are subtle and difficult to discern. As offenders progress through treatment in the institution the triggers and precursors are well documented and provide supervisory agents with important information that maximizes the effectiveness of supervision in the community. Furthermore, relapse prevention addresses the need for specialized supervisory practices and interagency collaboration when offenders are released into the community. The following section provides a brief synopsis of the treatment process followed by programs and interventions in the CEC continuum. The CEC continuum includes: Residential Assessment and Treatment, Residential Halfway Houses (halfway Back and halfway Out), Non Residential Day Reporting, Outpatient and Parole.

Residential Assessment and Treatment Programs

Residential Assessment and Treatment Programs are designed to serve substance use offenders who approach release from the institutional stay. These offenders are eligible for parole within 18 months or less when they enter the Residential Assessment and Treatment program. The program length is approximately 90 days for the Residential Assessment phase and approximately one year for the Treatment phase. Many of these offenders have been involved in substance use treatment during their institutional stay. During the first 30 days of a resident's stay in the program, a battery of psychological instruments is administered to determine program and aftercare needs. All assessments are conducted by professional staff members of an interdisciplinary treatment team. In accordance with licensure laws, all professional staff members are supervised by appropriately licensed professionals.

Insert Table 2 Here

The assessment battery includes a measure of personality, lethality, intelligence, psychosocial stressors and substance use history. A written evaluation is prepared for every resident. The results of the evaluation are integrated in the resident treatment plan and continuum of care plan. The assessment results provide detailed information for the NJDOC's Classification Committee so DOC personnel may determine where residents should be placed. Additionally, the results of the evaluation assist in specifying the actual type of aftercare services for each resident. Through an intricate system of working with the NJDOC and community service providers, an aftercare packet is prepared for community services. The aftercare packets identify the most critical areas in need of follow-up. For those specialized needs that may remain unaddressed while in the programs, specific treatment objectives are outlined for the community provider to address.

The treatment phase of the program consists of structured group counseling, individual counseling, substance use education and family interventions. The treatment philosophy is based in cognitive-behavioral approaches. Specifically, principles from Rational Emotive Behavioral Treatment (REBT) are implemented. Group counseling activities are a significant part of the treatment phase and consist of large lectures, structured process groups, caseload groups, resident seminars and creative therapies (i.e, anger management, conflict resolution, domestic violence, etc.).

Insert Table 3 Here

A major emphasis in the treatment program is the continuum of care plans. These plans provide each resident with opportunities to plan for community reintegration. Working with senior counselors, bachelor and masters prepared individuals, each resident reviews a variety of areas including: parenting, relapse prevention for substance use, relapse prevention for criminal behavior, emotional care, spiritual care, relationships, leisure time, housing, legal and financial care and aftercare planning.

Residential Halfway House Programs

Residential Halfway House Programs are designed to serve substance use offenders who have completed both the assessment and treatment phases of the continuum. The program length is approximately one year. Critical information from the Assessment and Treatment Programs is transferred to the staff members in the Residential Halfway House Programs. Each resident continues to matriculate through group interventions as aforementioned. The major difference with the Halfway House Programs and the Residential Assessment and Treatment program is the level of restrictiveness. These residents are involved in work release programs and are granted additional responsibilities. The treatment gains received in the aforementioned programs are expected to be generalized to the community. Residents are expected to manage their substance use urges and implement mental correctives to live crime free and substance use free lives. As the resident progresses through the treatment expectations, he/she applies for promotion to a lower level of care.

Residential Halfway Back/Out Programs are similarly structured as Halfway House programs. However, these programs are designed to treat offenders who have been released to parole and who have encountered problems. Generally, these residents have committed criminal acts of the magnitude that does not require a full commitment to an institutional stay. Instead of

returning to full custody, these residents return back to the halfway house programs for additional assessment, remedial treatment and aftercare interventions.

Non-Residential Day Reporting Programs

Non-Residential Day Reporting Programs are designed to serve substance use offenders who are eligible for such services. Generally, these offenders have completed the aforementioned treatment services. As such, they are considered less risky to violate parole conditions. Using specialized monitoring such as passive and active Global Positioning Satellite (GPS), electronic paging, and drug testing increases the range of options on the continuum in moving offenders from institutions to leading crime-free lifestyles in the community. However, these aspects of surveillance alone are not considered much help. Only when these services are combined with treatment and address precipitating circumstances are they effective.

Outpatient Programs

Outpatient Programs are designed to serve substance use offenders in the least restrictive settings. These offenders may receive a variety of services including substance use education, relapse prevention education, community reintegration, family interventions, alumni activities and alcoholics anonymous and narcotics anonymous (AA/NA) support groups. These offenders are expected to monitor their triggers and behaviors in order to facilitate substance use and crime-free lives. Specialized monitoring such as Global Positioning Satellite, increases the range of options on the continuum in moving offenders from institutions to leading crime-free lifestyles in the community.

Policy Implications and Lessons Learned

Since partnering with the New Jersey Department of Corrections (NJDOC), the CEC has discovered utility in addressing the needs of offenders approaching release from In-Prison stays.

The policy implications reported here is based on the lessons learned over the past nine years with the state of New Jersey criminal justice system. Those lessons formed the basis of the policy implications of this paper. Other lessons, including empirical validation of the program and whether the program results were related to the prevalence of criminal behavior and recidivism could not be answered with the available data or were not considered by state officials as crucial in determining whether to continue using the services. The following section presents critical policy implications and lessons learned:

1. A strong commitment from the top policy making and administrative level of the criminal justice system and the private organization, with agreement and support at the mid management level is critically necessary.
2. Explicit and formal arrangements need to be established so that community-based aftercare treatment providers maintain consistent contact that begins during the confinement period rather than just toward the end of the institutional stay.
3. A needs assessment by both agencies should be conducted. The needs assessment should examine the strengths and weaknesses of both systems. The assessment should include information on trends (i.e. arrests, demographics, etc.), substance use patterns and the needs of the community.
4. All program decisions must be based on the best practices research. Treatment interventions should be based on existing knowledge of crime and programs that show change. If clinical research is unavailable for the program model, national benchmarking of other community corrections programs should be conducted.

5. A standardized substance abuse curriculum that integrates criminal thinking patterns should be implemented. The curriculum should be outlined in smaller units that are presented in treatment stages.
6. A performance-based audit and evaluation process should be developed to determine the integrity of the program. The audits should occur regularly in order to establish corrective action plans.
7. Community safety must be adhered at all costs. Offenders must be closely monitored, while encouraging independence and community transition. If violations occur and are considered serious, the offender may be removed from the community altogether.
8. On-going collaboration with the department of corrections, parole and other treatment providers must be established. Treatment and correctional staff members must be cross-trained to understand the correctional treatment method.
9. All referrals to community-based programs should be based on the specific needs of the offender. Treatment resources should be allocated efficaciously.
10. On-going data collection must be implemented. The data collection activities might consist of clinical and behavior activities to measure program effectiveness and program integrity.

Policy implications and lessons learned along with recommendations are considered vital in the management and treatment of offenders in the community. These factors serve to continually improve the baseline services and program infrastructure to ensure consistent and sound correctional practices.

Summary

Offenders confined in correctional facilities with substance use histories have challenged state and private criminal justice systems. Increasingly, offenders enter the criminal justice system with significant substance use problems that must be addressed during the In-Prison stay. In order to maximize the benefits gained from the In-Prison substance use treatment, offenders must transfer the knowledge gained to the community. It is clear that a multi-stage substance use program delivery system must be developed to ensure treatment gains.

To address the substance use needs of offenders, the CEC created a comprehensive community corrections service delivery system for offenders committed to the New Jersey Department of Corrections. The CEC has specialized treatment facilities for providing a continuum of services: diagnostic and assessment, treatment, half-way houses, work release and specialized outpatient programs. These facilities are uniquely designed to meet the needs of offenders at several points along the continuum.

The current literature and the Community Education Center's (CEC) program of treatment and education services indicate the most effective Community Aftercare (CA) substance abuse treatment model is a cognitive behavioral based psychoeducational design. The development and implementation of this treatment model in a community-based corrections organization with proactive case management is a critical link point in promoting an inculcated sense of ownership in the post-released substance abuser (De Leon, 1991, 1994; Feldkamp, 1995). Community-based corrections' goal of public safety is obtainable by the incorporation of multistage treatment models that support recovery reinforcement. The measurable increases in self-esteem and core decision-making experienced by the post-released substance abuser will be

directly related to a desired decrease in the rates of recidivistic behaviors and trends (Feldkamp, 1995; Inciardi & Martin, 1997; Terry-McElrath et al., 2002).

This paper examined the existing literature on the viability of community corrections programs and its impact on the reduction of recidivism for substance abuse offenders who are approaching release. Additionally, it addressed the viability of linkage between institutional substance abuse treatment programming (ITC/TTC) and community-based aftercare (CA) intervention strategies (i.e., psychoeducational treatment approaches, CEC treatment model, and community-based correction's case management parole-probation's supervision). The results provide sufficient support for the concentrated efforts on the part of both law enforcement and community development officials to foster substance abuse treatment programming that is a cognitive behavioral based psychoeducational design.

Although this paper has been limited in its generalization by the absence of analytical data comparisons and contrasts, it nonetheless provides baseline information on community corrections programs. Future research should use both qualitative and quantitative strategies to determine the effectiveness of these programs. Additionally, the process of CA treatment programming reinforcement must be evaluated. Nonetheless, the emergence of the CEC's multistage modality interventions in substance abuse treatment can be a most productive fit with ITC/TTC – CA substance abuse post-release supervision and case management. It is hoped this effort will provide the supportive material needed to promote the efficacy of the dual goaled approach to public safety enhancement and reinforcement of substance abuser post-release recovery/ reduction of recidivism.

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Table 1: Continuum of Services

Continuum of Service



**Table 2:
Overview Assessment Instruments**

INSTRUMENTS/MEASURES	STAFF	TOTAL STAFF TIME	TOTAL RESIDENTS TIME	PERCENT RESIDENTS
ASSESSMENT				
Substance Abuse Subtle Screening Inventory (SASSI)	Clinicians	30 mins	30 mins	100%
The Level of Service Inventory-revised (LSI-R)	Clinicians	60 mins	60 mins	100%
Biopsychosocial Assessment	Clinicians	60 mins	60 mins	100%
The Clinical Interview	Clinicians	60 mins	60 mins	100%
Wonderlic Basic Skills Test (WBST)	Clinicians	30 mins	30 mins	100%
Self-Directed Search	Clinicians	30 mins	30 mins	100%
Wonderlic Personnel Test (WPT)	Clinicians	30 mins	30 mins	100%
SPECIAL CONSIDERATION INSTRUMENTS				
Anger Questionnaire (AQ)	Clinicians	20 mins	20 mins	Select
Spousal Assault Risk Assessment (SARA) Guide	Clinicians	60 mins	60 mins	Select
The Hare Psychopathy Checklist (PCL)	Clinicians	60+ mins.	60+ mins	Select
Personality Assessment Inventory (PAI)	Clinicians	60 mins.	60 mins	Select

Table 3: Overview of Secure Assessment and Treatment Clinical Services

SERVICE	FREQUENCY/DURATION	RESPONSIBLE PARTY	TOTAL HOURS
Assessment	1-2 Hours	Assessment Staff	2-4 Hours
Individual Counseling	2 Times Per Month - 1 Hour	Senior Counselor	6 Hours
Group Counseling			
Large Lecture	2 Times Per Day - 1 Hour	Senior Counselor	120 Hours
Process Group	2 Times Per Day - 1 Hour	Senior Counselor	120 Hours
Caseload Group	2 Times Per Week - 1 Hour	Senior Counselor	24 Hours
Resident Seminar	2 Times Per Week - 1 Hour	Counselor	24 Hours
Creative Therapy	1 Time Per Day - 1 Hour	Senior Counselor	60 Hours
AA Meetings	1 Time Per Day - 1 Hour	AA Facilitator	60 Hours
Family Intervention	1 Time Per Week - 2 Hours	Family Counselor	24 Hours

*Total Hours Based On 90 Day Program

Total Clinical Hours - 442

