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Response: Pathways to Recovery and Reintegration

Deanne Benos, B.A.; Flo Stein, M.A.; and Harry K. Wexler, Ph.D.

Harry K. Wexler: When I started out, there was very little treatment for offenders. Prisons were seen as warehouses, and "nothing works" was the prevailing belief. Then research started to demonstrate reductions in recidivism with therapeutic communities (TCs). Policymakers and legislators became very interested. TC became the dominant model throughout prisons. It is still prominent throughout the United States, especially in the California prison and parole system. However, there is now much diversity in these programs and curricula, with elements of cognitive-behavioral therapy (CBT), criminal thinking therapy, and Twelve Steps.

Flo Stein: As Dr. Prendergast (2009) writes, a number of therapeutic models have now been shown to be effective for offenders and parolees. In North Carolina, the State Department of Corrections provides CBT training for custody personnel who use it in the prison system. Part of the model's appeal is that CBT learning can be reinforced by community treatment providers and extended each time an offender re-enters the criminal justice system. The offender doesn't have to start over each time.

Deanne Benos: In Illinois, we've been working on a program called Operation Spotlight that uses CBT to address criminogenic factors among high-risk parolees. When parolees violate parole rules, have difficulty complying with the community treatment program, or show a high level of risk of returning to prison, we use a graduated sanctions process that includes sending them to Spotlight Re-Entry Centers. The centers—there are seven of them spread across the State—provide services, including individual counseling sessions, to parolees seeking assistance upon release from prison as well as to high-risk offenders. They have contributed to an 18 percent drop in new offense incarcerations between 2004 and 2007, resulting in the lowest annual rate on this measure in State history. In addition, the centers have helped reduce parole technical offense violations by nearly 40 percent from 2006 to 2008.

Stein: We're implementing a large-scale contingency management (CM) program in North Carolina. Some of our legislators went to a National Conference of State Legislatures meeting where CM was presented. They came back very enthusiastic and passed legislation that requires each of our programs to use up to 1 percent of its money for rewards and other incentives.

Wexler: That's quite an experiment. How's it working?

Stein: We're in our first year, so time will tell. I think some are using the model well, and others are still learning. I do think CM is an important strategy: Rewarding appropriate behaviors, such as showing up on time for treatment, participating in the group effectively, and things like that, can improve client motivation.

Wexler: The CM concept makes sense: Using positive rewards and counterpunches is simply Learning Theory 101. The National Development and Research Institute participated in a CM project that obtained positive results as part of NIDA's Criminal Justice–Drug Abuse Treatment Studies (CJ-DATS) project. However, CM's effect is limited in the offender population. As with any specialized intervention that does not treat the "whole" person, CM needs to be delivered in conjunction with other services. Although it certainly has a place in treatment of these patients, overreliance on it would be a mistake.

Pharmacotherapy, which Dr. Prendergast mentions only briefly, holds a lot of promise but has been ignored and unfairly criticized. Several studies have identified high death rates among releasees who are addicted to opioids. Members of this population are good candidates for methadone and buprenorphine. We should explore ways

to identify these individuals pre-release and to begin pharmacotherapy before they are paroled. With careful vetting and explicit guidelines, we can avoid a lot of the criticism and resistance to pharmacotherapy.

Assessment and management

Benos: I endorse Dr. Prendergast's view that recidivism should be the measure of success in treating substance-abusing offenders. Showing that we can keep people from returning to prison is the best way to encourage the public, government agencies, and politicians to support quality substance abuse treatment for prisoners and parolees.

Wexler: In my work in California and throughout my career, I've found that focusing on reducing recidivism is the best way to unite public health and criminal justice.

Stein: To me, a key principle advanced by Dr. Prendergast's paper is the importance of addressing parolees' treatment needs based on criminogenic risks.

Wexler: California prisons are implementing risk-needs assessments along the lines that Dr. Prendergast describes in his paper. For high-risk inmates and parolees, they're using CBT, criminal thinking models, and other kinds of behavioral curricula, some of which are commercially available as software packages or workbooks. That said, when it comes to assessing individuals to place them in prison aftercare, I don't think our procedures are as good as they need to be. They should enable us to adjust our assessments on a person-by-person basis and give us an array of treatment options for each individual. They don't generally do that yet.

Stein: Our assessments are now being done by Treatment Accountability for Safer Communities of North Carolina (TASC-NC). The objective is to enable judges and probation officers to assign services appropriately, which is particularly important because the State doesn't have the resources to provide judges with pre-sentencing evaluations. TASC-NC personnel work with community corrections officers to assess offenders' criminogenic and drug abuse risk levels and work out treatment plans. TASC-NC care managers are responsible for matching each offender to appropriate care. They can choose from any treatment program that the State provides, including TC, intensive outpatient, and residential care.

Wexler: Case management is a major step. Within prison, it can ensure continuity of care in the event of relocation due to crowding, security, and other reasons. Upon release, it can ensure that individuals receive the appropriate type of aftercare. One of our key recommendations for reforming California's prison system was to institute an ambitious case management system that follows offenders through prison and aftercare. Illinois' Sheridan program (see Heaps et al., 2009) was seen as a very useful model.

Benos: We work with Treatment Alternatives for Safe Communities (TASC) of Illinois to coordinate services for clinical reentry management for drug-abusing parolees. Illinois TASC staff begin clinical assessments before inmates are released from the Sheridan Drug Prison facility, and each inmate is assigned to an Illinois TASC case manager upon release. It has been a tremendous asset for us to have these case managers begin the work in the facility, with an understanding of what the inmate has gone through in his or her treatment program.

Still, getting individuals into aftercare following release is a challenge. For that reason, along with Illinois TASC, we bring the parole agent and others, such as community council members and religious figures, into the prison to establish a relationship as early as possible with each parolee and to conduct re-entry planning meetings at least 30 to 60 days prior to release. The community leaders get to know the parolee as a person. They can address his or her anxieties and concerns about returning home and, it is hoped, help with any difficult issues.

Wexler: The first 90 days post-release are crucial. It's a very tricky time, when lots of people get into trouble. Everything, even simple things like getting transportation from home to treatment and having necessary paperwork, must be carefully supervised.

Benos: The transition tends to go more smoothly when the integration between systems is tight. In Illinois, community service providers who wish to work with some of our programs must complete immersion training at the jail or prison facility. They must also be willing to coordinate services with our model and establish rapport and credibility with parole agents.

Stein: We have been talking about risk assessment, and responsivity is the other cornerstone of finding the right program for each individual. We don't always get the treatment fit right. If an offender is having trouble with the adjustment of re-entry or is relapsing, it might be that the program is not a match. In any treatment, there can be a number of problems: personality differences with the counselor, the wrong type of treatment program, an incompatible philosophical approach, or a lack of gender-specificity. In an effective model of prison aftercare, administrators must be able to respond to these issues. In the past, we thought that failures were the fault of the offenders, but often the the system is part of the problem.

Benos: Research like that reported in this paper makes it easier to communicate the idea that, even if an individual who has been through an intensive substance abuse program relapses, public safety has still been improved, because we've reduced numerous health and criminal risks for that individual. For example, consider a hypothetical offender with an extensive criminal history of violence related to substance abuse. If such an offender, after participating in a program, relapses and is rearrested for only a

minor possession or property offense, public safety has been improved. The lesser crime is an indication that the offender is slowly making progress. After another round of treatment, this individual might seek support through treatment or a support network before the next relapse instead of reoffending. Although public awareness has improved on this issue over the past two decades or so, the belief persists that if we invest tax dollars in a drug-involved individual with a criminal history, that person will stop using drugs immediately after completing the initial treatment program. In actuality, it's more of a gradual process.

Offenders in groups and as counselors

Wexler: One question we haven't addressed is whether treatment groups should include both releasees and substance abusers who are not involved in the criminal justice system. There are arguments to be made both for and against this approach. On the one hand, if you mix, you have to address criminogenic issues, criminal thinking, and other issues that aren't relevant to nonoffenders. Plus, probationers may have to meet certain criteria under varying levels of supervision, and programs need to know how to work with those requirements. On the other hand, our long-term goal is integration back into the community. At some point, I think it's a good idea to move toward heterogeneous treatment groups. You don't want to keep parolees and probationers in a secluded, isolated group.

Stein: True, but from the public policy point of view, we need to control criminal recruitment. We certainly don't put young offenders in groups with older male offenders. Also, we try not to mix women and men anymore. In essence, though, I agree with you that the end goal is integration. Plus, logistical matters can sometimes force those decisions upon you. In North Carolina, our population is spread out over a large rural area; out of necessity, our treatment programs are often mixed.

Wexler: What you said is absolutely right. At certain points in rehabilitation, people may be having difficulties or may be recruiting younger people, and there's the whole male-female problem. Those problems are important, and policy has to deal with them. Certainly, there are points in an individual's rehabilitation when you'd want to isolate him or her from a more general population. However, over the long run, if we're doing our job, offenders should move into the general population. Our challenge is to find a way to transition them successfully.

Stein: Also, our recovery programs involve giving back to the community and rehabilitating one's image in it. One way probationers can do that is by going to community treatment, contributing to the community, paying fines and restitution, and complying with requirements.

Wexler: Another way that ex-offenders can give back to the community is to find work as community treatment counselors. That way, they can make the problem into the solution. Going to school and getting credentialed are ways of reconnecting with the community and sustaining recovery. The more we welcome ex-offenders in recovery into the process and let them contribute, grow, and progress along career paths, the better. I think that's a major contribution, and one that inspires those in prison. When these individuals return to places like Sheridan, they are perceived as very credible by those in treatment.

Benos: We hire former prisoners at Sheridan and contract with provider organizations that are run or staffed by former prisoners. Now that Sheridan has been open for 4 or 5 years, some programs even employ Sheridan graduates, which provides a lot of motivation for current participants.

Stein: Credentialing can be a problem, though. It involves hundreds of hours of training, supervision in the research and practice of both justice and treatment, and an examination. It's pretty rigorous. A recovering person can qualify, however, and certainly his or her life experiences provide insight and credibility.

Wexler: Education and vocational training don't have to involve preparation for becoming an addiction counselor, necessarily. Data show that education and career preparation of all kinds are very good recidivism reducers. They give a person tools for recovery and help the person to adapt to and participate in the community constructively.

Stein: Self-care is an important part of all addiction treatment. It would be fruitful to investigate how much responsibility we're giving the offender toward achieving and maintaining recovery. These guys like having the responsibility.

Wexler: I agree, and to build on that, I think we should do more to welcome prison inmates with addictions as collaborators in the work toward their own recovery. We should be asking them what they need from treatment, how they see it progressing, and how we can work with them. In our process, we don't tend to pay sufficient attention to the voices of offenders or ex-offenders.

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