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THERAPEUTIC COMMUNITIES IN PRISONS AND WORK RELEASE:
Effective Modalities for Drug-Involved Offenders

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The problems of implementing drug treatment programs in correctional settings is often difficult, because despite any arguments to the contrary, the primary task of prisons is custody. The internal order of the prison is maintained by strictly controlling the inmates and regimenting every aspect of their lives. In addition to their loss of freedom and basic liberties, goods and services, heterosexual relationships, and autonomy, they are deprived of their personal identities. Upon entering prison, inmates are stripped of their clothing and most of their personal possessions; and they are examined, inspected, weighed, documented, classified, and given a number. Thus, prison becomes painful, both physically and psychologically (Clemmer 1958; Sykes 1965).

The rigors and frustrations of confinement leave but a few paths open to inmates. They can bind themselves to their fellow captives in ties of mutual aid and loyalty, in opposition to prison officials. They can wage a war against all, seeking their own advantage without reference to the needs and claims of others. Or they can simply withdraw into themselves. Ideally, these alternatives exist only in an abstract sense, and most inmates combine characteristics of the first two extremes. Within this balance of extremes an inmate social system emerges and functions, and one of the fundamental elements of this social system is the prison subculture.

Every correctional facility has its subculture, and every prison subculture has its system of norms that influence prisoners' behavior, typically to a far greater extent than the institution's formally prescribed rules. These subcultural norms are informal and unwritten rules, but their violation can evoke sanctions from fellow inmates ranging from simple ostracism to physical violence and death. Many of the rules revolve around relations among inmates and interactions with prison staff, while others reflect preoccupations with being "smart," "tough," and street

wise. As such, this prison code often tends to militate against reform in general, and drug rehabilitation in particular (Inciardi, Lockwood and Martin 1991).

In addition, there are many other phenomena in the prison environment that make rehabilitation difficult. Not surprisingly, the availability of drugs in prisons is a pervasive problem. Moreover, in addition to the one-on-one assaults that seems to be a concomitant of prison life, there is the violence associated with inmate gangs, often formed along racial lines for the purposes of establishing and maintaining status, "turf," and unofficial control over certain sectors of the penitentiary. Within this setting, it would appear that if any drug rehabilitation approach had a chance of succeeding, it would be the therapeutic community.

Therapeutic Communities in Corrections

The therapeutic community (or "TC") is a total treatment environment that can be isolated from the rest of the prison population -- separated from the drugs, the violence, and the norms and values that rebuff attempts at rehabilitation. Like therapeutic communities in free society, the primary clinical staff of the TC are typically former substance abusers -- "recovering addicts" -- who themselves were rehabilitated in therapeutic communities. The treatment perspective of the prison TC is also the same, 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. In the prison TC's view of recovery, the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use. As such, the overall goal is a responsible drug-free lifestyle (De Leon and Ziegenfuss 1986; Yablonsky 1989).

The Staging of Corrections-Based TC Treatment

Based on experiences with correctional systems and populations, with corrections-based drug treatment, and with the evaluation of a whole variety of correctional programs, it would appear that the most appropriate strategy for effective TC intervention with inmates would involve a three-stage process (Inciardi, Lockwood and Martin 1991). Each stage in this regimen of treatment would correspond to the inmate's changing correctional status -- incarceration, work release, and parole (or whatever other form of community-based correction operates in a given jurisdiction).

The *primary stage* should consist of a prison-based therapeutic community designed to facilitate personal growth through the modification of deviant lifestyles and behavior patterns. Segregated from the rest of the penitentiary, recovery from drug abuse and the development of pro-social values in the prison TC would involve essentially the same mechanisms seen in community-based TCs. Therapy in this primary stage should be an on-going and evolving process. Ideally, it should endure for 9 to 12 months, with the potential for the resident to remain longer, if necessary. As such, recruits for the TC should be within 18 months of their work release date at the time of treatment entry.

It is important that TC treatment for inmates begin *while they are still in the institution,* for a number of reasons. In a prison situation, time is one of the few resources that most inmates have an abundance of. The competing demands of family, work, and the neighborhood peer group are absent. Thus, there is the *time* and opportunity for 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 education, training, and understanding of the addiction cycle.

Since the 1970s, work release has become a widespread correctional practice for felony offenders. It is a form of partial incarceration whereby inmates are permitted to work for pay in the free community but must spend their nonworking hours either in the institution, or more commonly, in a community-based work release facility or "halfway house." Inmates qualified for work release are those approaching their parole eligibility or conditional release dates. Although graduated release of this sort carries the potential for *easing* an inmate's process of community reintegration, there is a negative side, especially for those whose drug involvement served as the key to the penitentiary gate in the first place.

This initial freedom exposes many inmates to groups and behaviors that can easily lead them back to substance abuse, criminal activities, and reincarceration. Even those receiving intensive therapeutic community treatment while in the institution face the prospect of their recovery breaking down. Work release environments in most jurisdictions do little to stem the process of relapse. Since work release populations mirror the institutional populations from which they came, there are still the negative values of the prison culture. In addition, street drugs and street norms tend to abound.

Graduates of prison-based TCs are at a special disadvantage in a traditional work release center since they must live and interact in what is typically an anti-social, nonproductive setting. Without clinical management and proper supervision, their recovery can be severely threatened. Thus, secondary TC treatment is warranted. This *secondary stage* is a "transitional TC" -- the therapeutic community work release center.

The program composition of the work release TC should be similar to that of the traditional TC. There should be the "family setting" removed from as many of the external negative influences of the street and inmate cultures as is possible; and there should be the hierarchical system of ranks and job functions, the rules and regulations of the environment, and the complex of therapeutic techniques designed to continue the process of resocialization. However, the clinical regimen in the work release TC must be modified to address the correctional mandate of "work release."

In the *tertiary stage,* clients will have completed work release and will be living in the free community under the supervision of parole or some other surveillance program. Treatment intervention in this stage should involve out-patient counseling and group therapy. Clients should be 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 participate in monthly one-to-one and/or family sessions. They should also be required to spend one or more days each month at the program, and a weekend retreat every three months.

The TC Continuum in the Delaware Correctional System

This three stage model has been made operational within the Delaware correctional system, and is built around three therapeutic communities -- the KEY Arena, the Key Village, and CREST Outreach Center.

The KEY Arena. The KEY Arena is a prison-based therapeutic community for male inmates located at the Multi-Purpose Criminal Justice Facility in Wilmington, Delaware. Also known as "KEY North," it represents the primary stage of TC treatment, and was established in

1988 through a Bureau of Justice Assistance grant. In 1990, the State of Delaware assumed the funding of the program, expanding it from its original 40 beds to 70, with further expansions is subsequent years. By 2000, the Key Arena (or KEY North) had a capacity of 240 beds and a staff of 15. During 1999, furthermore, two additional prison-based TC programs for men were established: KEY West, a 90-bed facility in central Delaware; and KEY South, a 300-bed facility in the southern part of the state.

In general terms, the treatment regimen at the KEY Arena follows an holistic approach. Different types of therapy -- behavioral, cognitive, and emotional -- are used to address individual treatment needs (Hooper, Lockwood and Inciardi 1993). Briefly:

1. *Behavioral Therapy* fosters positive demeanor and conduct by not accepting antisocial actions. To implement this, behavioral expectations are clearly defined as soon as a new resident is admitted to the program. At that time, the staff's primary focus is on how the resident is to behave. The client works with an orientation manual which he is expected to learn thoroughly. Once again, the focus is on his behavior as opposed to thoughts and feelings. As the client learns and adjusts to the routines of the therapeutic community, more salient issues are dealt with in the treatment process.

2. *Cognitive Therapy* helps individuals recognize errors and fallacies in their thinking. The object is to help the client understand how and why certain cognitive patterns have been developed across time. With this knowledge the client can develop alternative thinking patterns resulting in more realistic decisions about life. Cognitive Therapy is accomplished in both group and individual sessions.

3. *Emotional Therapy* deals with unresolved conflicts associated with interactions with others and the resulting feelings and behaviors. To facilitate this treatment strategy, a non-threatening but nurturing manner is required so that clients can gain a better understanding of how they think and feel about themselves as well as others.

A number of techniques are employed to implement these three alternative therapeutic approaches and to motivate individuals to change, including transactional analysis, psychodrama, and branch groups. *Transactional analysis* involves a detailed assessment of the roles that one plays in interactions with others. The ego states affecting behavior are defined in terms of "parent," "adult," and "child." Through group and individual sessions, clients are taught how to recognize which ego state they typically select for certain interactions and the effects of allowing their behavior to be controlled by that ego state.

In the *psychodrama,* individuals relive and explore unresolved personal feelings and thoughts. Through this process, clients are helped to bring to closure unresolved issues which have prevented them from developing more adequate life-coping skills. Group and individual sessions are used as the vehicle for this treatment.

In *branch groups,* clients meet on a routine basis to share both feelings and thoughts about the past and present. In-depth thoughts and feelings are dealt with so that there can be a better understanding of how a person is perceiving his world. With this understanding, he is in a better position to develop more adequate coping skills.

The KEY Village. The KEY Village is a prison-based therapeutic community for women inmates located at the Baylor Women's Correctional Institution in New Castle, Delaware.

Like The KEY Arena, the KEY Village represents the primary stage of TC treatment, and was established in during the closing months of 1993 through a Center for Substance Abuse Treatment grant. The Village follows a treatment regimen similar to that at The KEY Arena, but with adaptations designed specifically for women. The capacity of the KEY Village is currently 42 beds.

CREST Outreach Center. During the closing months of 1990, the Center for Drug and Alcohol Studies at the University of Delaware was awarded a 5-year treatment demonstration grant from the National Institute on Drug Abuse to establish a work release therapeutic community. Known as "CREST Outreach Center," it represented the first dedicated work release TC in the nation, and it was designed to incorporate stages 2 and 3 of the treatment process outlined above.

The treatment regimen at CREST Outreach Center follows a 5-phase model over a 6-month period. *Phase One* is composed of entry, assessment and evaluation, and orientation, and lasts approximately two weeks. New residents are introduced to the house rules and schedules by older residents. Each new resident is also assigned a primary counselor, who initiates an individual needs assessment. Participation in group therapy is limited during this initial phase, so that new residents can become familiarized with the norms and procedures at CREST.

Phase Two emphasizes involvement in the TC community, including such activities as morning meetings, group therapy, one-on-one interaction, confrontation of other residents who are not motivated toward recovery, and the nurturing of the newer people in the environment. During this phase, residents begin to address their own issues related to drug abuse and criminal activity, in both group sessions and during one-on-one interactions. As well, they begin to take

responsibility for their own behaviors by being held accountable for their attitudes and actions in group settings and in informal interactions with residents and staff. Residents are assigned job functions aimed at assuming responsibility and learning acceptable work habits, and they continue to meet with their primary counselors for individual sessions. However, the primary emphasis in Phase Two is on becoming a active community member through participating in group therapy and fulfilling job responsibilities necessary to facility operations. This phase lasts approximately eight weeks.

Phase Three continues the elements of Phase Two, and stresses role modeling and overseeing the working of the community on a daily basis (with the support and supervision of the clinical staff). During this phase, residents are expected to assume responsibility for themselves and to hold themselves accountable for their attitudes and behaviors. Frequently, residents in this phase will confront themselves in group settings. They assume additional job responsibilities by moving into supervisory positions, thus enabling them to serve as positive role models for newer residents. They continue to have individual counseling sessions, and in group sessions they are expected to help facilitate the group process. Phase Three lasts for approximately 5 weeks.

Phase Four initiates preparation for gainful employment, including mock interviews, seminars on job seeking, making the best appearance when seeing a potential employer, developing relationships with community agencies, and looking for ways to further educational or vocational abilities. This phase focuses on preparing for re-entry to the community and lasts approximately two weeks. Residents continue to participate in group and individual therapy, to be responsible for their jobs in the CREST facility. However, additional seminars and group

sessions are introduced to address the issues related to finding and maintaining employment and housing as well as returning to the community environment.

Phase Five involves "re-entry," i.e., becoming gainfully employed in the outside community while continuing to live in the work release facility and serving as a role model for those at earlier stages of treatment. This phase focuses on balancing work and treatment. As such, both becoming employed and maintaining a job are integral aspects of the TC work release program. During this phase, residents continue to participate in house activities, such as seminars and social events. They also take part in group sessions addressing issues of employment and continuing treatment after leaving CREST. In addition, residents begin to prepare to leave CREST. They open a bank account and begin to budget for housing, food, and utilities. At the end of approximately 7 weeks, which represents a total of 26 weeks at CREST Outreach Center, residents have completed their work release commitment and are free to live and work in the community as program graduates.

The CREST Outreach Center community is comprised of women and men at a variety of stages of treatment. Through this interaction, newer residents are given hope and encouragement for changing their lifestyles and the older residents can assess their own changes and become positive role models. Moreover, beginning in Phase Two, residents are encouraged to engage family and significant others in the treatment process through family and couples groups led by CREST counselors.

At the beginning of 2000, CREST Outreach Center had three coeducational facilities: CREST North, housing 112 work release clients; CREST Central, housing 125 Clients; and CREST South, housing 148 clients.

Aftercare North and South. Because the majority of CREST graduates have probation and/or parole stipulations to follow after their period of work release, an *aftercare* component was been developed to ensure that graduates fulfilled probation/parole requirements. This represents the tertiary phase of treatment, providing continued treatment services so as to decrease the risk of relapse and recidivism. This aftercare program endures for six months, and requires total abstinence from illegal drug use, one two-hour group session per week, individual counseling as scheduled, and urine monitoring. Graduates must return once a month to serve as role models for current CREST clients. Participation in a 12-step AA (Alcoholics Anonymous and/or NA (Narcotics Anonymous) program is also encouraged.

Methods

The Center for Drug and Alcohol Studies at the University of Delaware is currently funded by the National Institute on Drug Abuse (NIDA) to evaluate the relative effectiveness of the prison and work release treatment programs described above. In recent years evaluation funding has also come from the National Institute of Justice and the Center for Substance Abuse Treatment. [All of these U.S. Government agencies haver a continuing interest in treatment alternatives for drug-involved offenders.] Participation in the project is voluntary, and clients are protected by a Certificate of Confidentiality issued by NIDA. About 95% of all eligible subjects have agreed to participate in the study at baseline, and over 80% of those interviewed also provided a urine specimen. Follow-up rates for all study participants have been about 80%.

The baseline interview was administered in prison, just prior to the inmate's transfer to CREST Outreach Center or regular work release. The baseline assessment collected self-report data on basic demographics, prior living situation, criminal history, drug use history, treatment

history, sexual behavior history, sexual attitudes, HIV risks, and physical and mental health. Previous use of a series of illegal drugs was measured on an ordinal scale ranging from 0 (no use) to 6 (use more than once a day) in the 6 months prior to incarceration.

The first follow-up assessment occurred six months after release from prison, corresponding with graduation from CREST (for the treatment groups) or completion of regular work release (for the control group). Subsequent interviews were conducted 18 months and 42 months after release. Treatment dropouts were also followed up at these time points. Follow-up surveys elicited detailed information about drug use and criminal activity during the intervening time periods. In addition, the follow-up interviews collected information on the amount of time spent in any drug treatment program since release from prison. This is important because the comparison sample was not truly a *no treatment* group. Many of these offenders sought treatment on their own during work release, and this treatment status should be controlled for in outcome analyses.

The dependent variables for the analyses presented here are dichotomous measures of relapse to illegal drug use and re-arrest at the 42 month follow-up. Each outcome measure was constructed from repeated self-report data and objective criteria. To be considered "drug free," the respondent must have reported *no* illegal drug use and have tested negative for drugs on the urine screen at each follow-up point. As such, this is an extremely conservative criterion since drug use on even one occasion during the follow-up period would negate the "drug free" status. Similarly, the criteria for "arrest free" included no self-reports of arrest and no official arrest records for new offenses since release from prison.

The data were analyzed using a multivariate logistic regression technique, with treatment status (treatment graduates with aftercare, treatment graduates with no aftercare, treatment dropouts, and no treatment), and a number of other putative predictors of relapse and recidivism included as possible explanatory variables in the model. These additional predictors include age, gender, race/ethnicity, age at first arrest, number of previous arrests, number of times in prison, frequency of prior drug use, and history of drug treatment. These control variables are not only potential predictors of treatment outcome, but more importantly, they are factors that may differ across groups since group membership was not randomly assigned.

Results

Table 1 presents the baseline sample characteristics by treatment status for those study participants with 42 month follow-up data. Sample attrition has generally been low (less than 10% between the 18 and 42 month follow-ups), and importantly, does not differ significantly between the treatment and comparison groups.

Insert Table 1 About Here

There do appear to be some differences in group characteristics, primarily in terms of their gender and racial composition, but also with regard to prior drug treatment history. In order to control for these differences, the logistic regression models predicting drug use relapse and recidivism incorporated each factor displayed in table 1, as well as treatment group status. Looking first at the control variable effects in the multivariate logistic regression analyses, age and previous arrest history predicted new arrest, and there was also a small effect of previous

drug history on the likelihood of recidivism. That is, older participants were less likely to be arrested for new crimes, while those with more previous arrests were more likely to have been re-arrested by 42 months after release. For the logistic regression model predicting drug relapse, the only significant control variable was prior drug history.

Figures 1 and 2 present the results of the logistic regressions predicting re-arrest and relapse to drug use by treatment status, holding the control variables constant.

Insert Figures 1 and 2 About Here

An examination of the Arrest Free panel reveals that treatment dropouts are just as likely as the comparison group to be arrested on a new charge. However, those that complete treatment fare significantly better (p=.004), and those who complete treatment and get aftercare are the most likely to be arrest-free (p=.000). Less than one-third of the clients completing treatment with aftercare have been re-arrested, while more than two-thirds of the comparison group have been re-arrested by the 42 month follow-up.

The beneficial effects of the both treatment and aftercare are equally apparent when Drug Free status is examined in Figure 2. When contrasted with the comparison group in which only 5% have remained drug free since release from prison, treatment dropouts are more than three times as likely to be drug-free (p=.017), treatment graduates more than five times as likely (p=.001), and treatment graduates with aftercare are seven times more likely to be drug-free (p=.000). These data provide compelling evidence that participation and completion of

transitional and aftercare treatment programs provides a significant and incremental protective factor against both relapse and recidivism.

Discussion

The typically longstanding drug and criminal careers of offenders coming to the attention of the criminal justice system in Delaware necessitates that the successful substance abuse treatment approach be both intensive and extensive, comprising a continuum of *primary* (in prison), *secondary* (work release), and *tertiary* (aftercare) therapeutic community (TC) treatment corresponding to sentence mandates. The outcome data presented here indicated that clients who completed *secondary* treatment (some of whom also completed *primary* treatment) were significantly more likely than those with no treatment or those who dropped out of treatment to remain drug-free and arrest-free three years after release from prison. In addition, preliminary analyses of data now available on Delaware clients who received *tertiary* treatment (a TC aftercare program implemented in 1996) suggest that treatment graduates who participate in aftercare programming surpass treatment graduates who do not receive continuing care in terms of remaining drug and arrest-free at 42 months. These results provide continuing support for the beneficial effects of participation in institutional, transitional and community TC treatment for drug-involved offenders.

It should be noted, however, that the 42 month outcome data presented here are preliminary, as follow-ups are still underway. As we collect long-term follow-up data on more clients, several more comprehensive analyses will be conducted. In particular, the effects of length of time in each phase of treatment, as well as completion of each phase, will be examined

more fully. For example, the analyses presented here do not delineate the effects of participating in the in-prison TC program, although there is some indication that graduates of the institutional TC are more likely to remain in treatment through work release and aftercare. As more follow-up data are collected and the sample sizes increase, it will be possible to model the effects of all stages of the treatment continuum simultaneously.

There are other limitations to the present analysis that will be addressed in future work. In particular, it is clear that the models estimated, although significant, are not accounting for all of the variance in predicting relapse and recidivism. It is likely that important control variables and possible confounding variables for group effects have not been modeled. One such area that will be considered in future analyses is the compulsory or voluntary nature of the treatment entry (Leukefeld & Tims, 1988; De Leon, Inciardi, & Martin, 1995). The Delaware TC programs contain both treatment volunteers and mandates, and this status needs to be incorporated into future models of treatment effects predicting relapse and recidivism. Yet, despite these limitations, the present data support the value of treatment in work release and parole settings and the importance of retention in treatment in increasing long-term abstinence from drug use and criminal activity. More generally, the data also support some long-held beliefs about the beneficial effects of aftercare (De Leon, 1990-1991; Inciardi & Scarpitti, 1992; Wexler et al., 1999).

Table 1. Baseline Characteristics of Comparison and Treatment Samples

	COMPARISON	TREATMENT DROP OUTS	TREATMENT GRADUATES	TREATMENT GRADUATES WITH AFTERCARE
N	210	109	101	69
Age (Mean)	29	29	31	31
Age at 1st Arrest	22	20	21	23
Mean # of Times in Prison	4	4	4	4
Mean # of Arrests	10	13	13	11
Males (%)	82	83	76	67
Whites (%)	28	21	15	20
Hispanic (%)	3	4	2	2
African-Americans (%)	68	74	83	74
Other Race (%)	–	–	–	4
Scale of Drug Use 6 Mos. Prior to Prison, ranging from 0 (none) to 6 (several times/day)	4	4	5	4
Prior Drug Treatment (%)	74	79	79	88

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FIGURE 1. Percent Arrest-Free 42 Months After Release from Prison (adjusted for control variables)

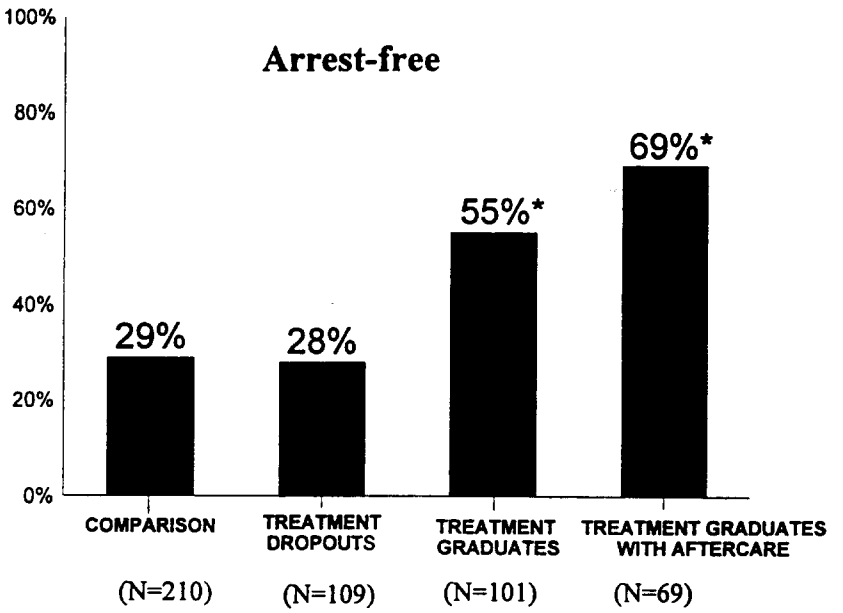
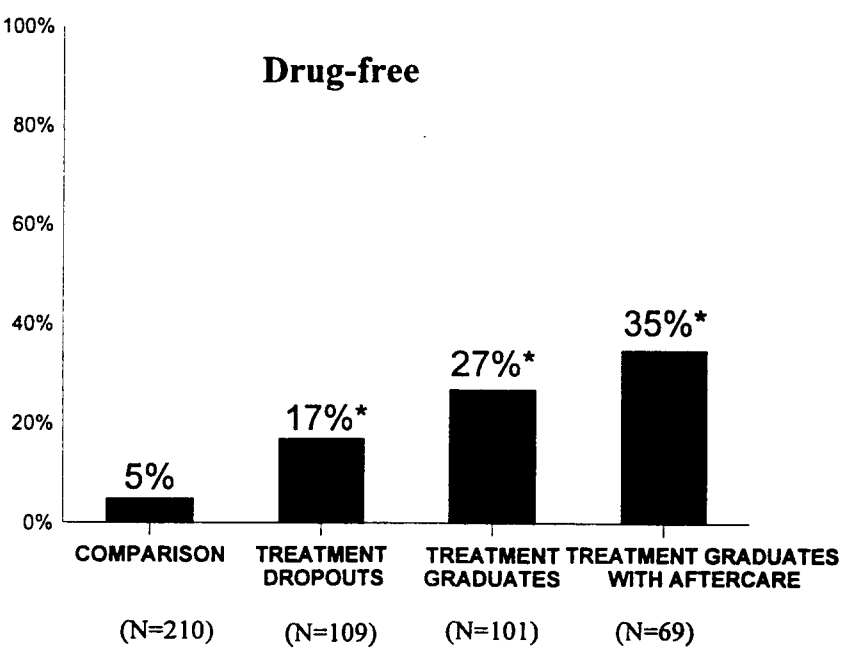


FIGURE 2. Percent Drug-Free 42 Months After Release from Prison (adjusted for control variables)



[* Significantly different from COMPARISON group, $p<.05$]