

Research in Review

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Division of Planning, Research, Statistics and Grants

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Special Focus on *Therapeutic Communities*

This issue of *Research in Review* includes two special research briefing papers on therapeutic communities, or “TC’s”. These papers offer the reader insight into the latest and best research available on intensive strategies for the treatment of severely addicted offenders, both within prison and in the community. These papers expand upon the paper *Offender Treatment Programs: What Works and How*, featured in Volume 4, Number 1 of RIR.

The first paper, *Prison-based Therapeutic Community Treatment*, presents an overview of the research on the effectiveness of prison TC’s for the treatment of alcohol and other drug abuse. This paper reviews recent studies of such TC’s, and discusses how their performance has been assessed. Measures of effectiveness include recidivism, inmate institutional behavior and cost savings. This paper concludes that TC’s can be an effective model of treatment for the seriously addicted inmate.

The second paper, *Therapeutic Communities and Aftercare in the Community*, expands the discussion of TC’s to the post-release setting. There is a growing consensus in the literature that prison-based treatment *alone* does not achieve the full potential for preparing addicted inmates to reenter society. Institutional treatment programs should be supplemented by treatment and reentry services in the community. This paper examines strategies for such treatment, and discusses the broader policy context in which such treatment efforts operate. This piece provides interesting insight into the idea of a continuum of treatment.

Upcoming issues of RIR will include briefing papers on correctional education programs, aftercare and other issues. We at RIR hope that you find these papers to be informative, practical and relevant to your work in corrections.

PRISON-BASED THERAPEUTIC COMMUNITY TREATMENT

by

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Therapeutic communities (TC's) for the treatment of abuse of alcohol and other drugs (AOD) are some of the most intensive treatment regimens available in prisons for seriously addicted offenders. The TC treatment model typically operates in four stages, for a total time in treatment of six to twelve months. TC's are full-time residential treatment units; inmates in the TC are segregated as much as possible from the general inmate population. Specific treatment modalities include individual and group counseling, alcohol and other drug education, relapse prevention and cognitive-behavioral skill-building activities designed to address criminogenic risk factors (e.g. criminal thinking, poor decision making skills, anti-social attitudes, etc.). Inmates in a TC are expected to assume increasing levels of responsibility for coordinating the daily activities of the unit. In this way, inmates are introduced to the concepts of community and self-responsibility, and thus learn what it means to participate in a civic community (Office of National Drug Control Policy, 1999).

There is a growing body of research that supports the effectiveness of AOD TC's. Major evaluations of prison-based TC's in California, Delaware, Pennsylvania and Texas have been conducted over the past several years, with funding from the National Institute of Justice and the National Institute on Drug Abuse. A special issue of *The Prison Journal*, from September of 1999, presented a comprehensive review of recent evaluations.

Research on the Amity prison TC in California found that only 27 percent of inmates who completed both the TC and aftercare returned to prison within three years of release, compared to 75 percent of similar inmates who had no such treatment (the comparison group). Moreover, treated inmates who did return to prison succeeded on the street for an average of 579 days before failing, compared to only 295 days for the untreated inmates, a difference of over nine months (Wexler, et al. 1999). A cost-benefit analysis conducted on this program by the California legislature concluded that if the impacts of this TC could be replicated more broadly throughout the California prison system, projected prison expansion over the next seven years could be reduced by 4,700 beds, for an annual savings of over \$80 million (Mullen, et al. 2001). Other evaluation activities of the Amity program found benefits in terms of reduced misconducts and prison violence by inmates who received treatment (Deitch, et al. 1998).

An evaluation of the KEY-CREST prison TC and community aftercare program in Delaware found that inmates who completed all phases of treatment had a rearrest rate of only 31 percent after three years, compared with 71 percent for similar inmates without treatment (Martin, et al. 1999). A separate evaluation also found that inmates who had completed KEY-CREST had significantly higher levels of employment and legitimate income after release than was the case for untreated ex-

offenders (Butzin, et al. 1999). This study also found markedly lower levels of relapse to drug use among TC completers who were *not* able to secure stable employment after release. Thus, TC treatment seemed to have benefits for released offenders who might otherwise be at especially high risk for relapse and recidivism.

Studies of the Kyle New Vision ITC prison-based TC in Texas concluded that this treatment had a significant impact on the most severely addicted inmates. The three year reincarceration rate for inmates who completed all phases of ITC treatment was 26 percent, compared with 52 percent for similar inmates who had no treatment. This study also found that only six percent of the inmates who completed the ITC *and* returned to prison committed new crimes (the remainder were returned for technical parole violations), whereas 19 percent of the returning inmates who had no treatment were reincarcerated for new crimes (Knight, et al. 1999). A cost-effectiveness analysis conducted as a companion piece to this evaluation concluded that, given the reductions in recidivism that resulted from completion of the prison-based treatment and aftercare, this regimen is a cost-effective alternative to providing no treatment to seriously addicted inmates. The cost-effectiveness was found to be greatest for seriously addicted inmates (Griffith, et al. 1999).

The results of these national TC evaluations are summarized in the table below. Two comprehensive outcome evaluations of TC's in Pennsylvania State Correctional Institutions (SCI's) are presently underway, with results anticipated in 2002. The already completed process evaluation of the full range of AOD programs offered in the SCI's concluded that TC has the greatest likelihood of producing measurable reductions in recidivism.

SUMMARY OF EVALUATIONS OF PRISON THERAPEUTIC COMMUNITIES (TC's)				
State	TC Name	Impact on Recidivism (3 years after release)	Cost Savings	Other Findings
California	Amity	Treatment Group: 27 % Comparison Group: 75 % reincarceration rates	Projected \$80 million savings over 7 years.	Inmates in TC had fewer misconducts while in prison.
Delaware	KEY-CREST	Treatment Group: 31 % Comparison Group: 71 % rearrest rates	N/A.	Significant impact on employment of treated inmates.
Texas	Kyle New Vision ITC	Treatment Group: 26 % Comparison Group: 52 % reincarceration rates	Treatment for seriously addicted inmates most cost-effective.	Very few treated inmates returned to prison for new crimes.

Results abstracted from: *The Prison Journal*, Volume 79, Numbers 3 & 4 (September and June 1999); and *Offender Substance Abuse Report*, Volume 1, Numbers 1 & 2 (2001).

In sum, the existing body of evaluation literature on prison-based TC's has supported a widely accepted conclusion in the corrections field that TC is an effective and efficient means of addressing the problems of seriously addicted offenders. This conclusion is in line with the mounting evidence from evaluations of all types of substance abuse treatment programs (for both criminal and non-criminal populations) that time-in-treatment is one of the most powerful predictors of program

success, with the ideal time being from three to twelve months, depending upon the specific nature of the problem and the characteristics of the individual (see the next paper for more detail on this issue). There is also increasing focus in the evaluation literature on the importance of aftercare following TC treatment, both within the institution and on the street (see Gendreau, 1996; Hanlon, et al. 2000; Knight, et al. 1999). Clearly, an intensive treatment regimen in prison, coupled with follow-up care, offers hope for rehabilitation to seriously addicted inmates.

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THERAPEUTIC COMMUNITIES AND AFTERCARE IN THE COMMUNITY

by

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As demonstrated in the preceding paper, there is a growing body of evaluation literature on the effectiveness of prison-based therapeutic communities (TC's). Correctional institutions, though, are only one locus of intensive drug treatment for offender populations. Community-based therapeutic communities are also available to offenders who need ongoing, intensive treatment after their release from incarceration. The body of research on the effectiveness of community-based TC's, however, is rather more thin than that available on prison-based TC's. Rather, much of the existing research emphasizes general principles of effective intervention and focuses on a continuum-of-care that includes prison-based programming followed by community-based treatment.

The linkages between substance abuse and crime have been documented extensively by both the National Institute on Drug Abuse and the National Institute of Justice (Inciardi, et al. 1997). National studies report that the majority of offenders behind bars have been involved with illicit drugs, with as many as 83 percent of all prisoners reporting some past drug use, while 57 percent used drugs one month prior to their crime and 33 percent reported using drugs while committing their last offense (Griffith, et al. 1999). In Pennsylvania, this equates to more than 30,000 current inmates who have used drugs in the past and to over 12,000 who used drugs when they committed their last offense. When one considers that substance abuse is a strong indicator of risk and combine that with overall findings that indicate that drug use intensifies and perpetuates criminal activity, it is clear that criminal justice settings have become excellent opportunities for assessment and treatment of offenders with substance abuse problems.

The therapeutic community model has been proven to be a successful treatment intervention in studies undertaken in Delaware, California and Texas. The primary objective of a TC is to foster personal growth and change. Therapeutic communities use a combination of counseling, group therapy and peer pressure to rehabilitate hardcore substance abusers and assist them in redirecting their lives toward positive goals. These types of programs provide a family-like environment in which honesty, trust, and self-help are stressed, and where discipline and adherence to rules make clear the seriousness of the work at hand (Office of National Drug Control Policy, 1999).

The rationale for TC-based treatment in prisons is that the substance abuse problems characteristic of most inmates require high-intensity treatment to restructure attitudes and thinking and to provide the social and relapse prevention skills necessary for improving adjustment in the community following release (Wexler, et al. 1999). Offenders come to understand that reaching their initial goals while in treatment is the first step, *and that they will be expected to continue to use the tools acquired in treatment for the rest of their lives* (Office of National Drug Control Policy, 1999).

Several recent evaluations support the effectiveness of in-prison treatment, *especially when followed by residential aftercare*, for reducing recidivism and relapse rates and for improving parole outcomes. For purposes of comparison to Pennsylvania, residential aftercare would be considered ongoing TC treatment while released to a Community Corrections Center. However, more work is needed to determine which factors should be considered when placing offenders in treatment. One promising area of study is offender risk classification, the formal assignment of the probability of recidivism based on standard screening instruments (Griffith, et al. 1999).

The completion of in-prison treatment and aftercare is a cost-effective alternative when compared with incarceration without treatment. These effects were most pronounced for high-risk parolees in a study conducted in Texas. If untreated, 52 percent of high-risk parolees were reincarcerated within 3 years, versus 29 percent of those who were low risk. However, only about one fourth of the treatment and aftercare completers from each risk group were reincarcerated (26 percent for high-risk vs. 22 percent for low-risk parolees). In other words, the high-risk offenders showed a much greater improvement with a combination of in-prison treatment and aftercare than did those considered low-risk (Griffith, et al. 1999).

Consequently, it appears that intensive services provided to low-risk parolees were not a particularly good investment of public monies, especially when they failed to complete treatment. This finding does not suggest that low-risk drug-involved parolees do not need treatment, but perhaps they could be served more cost-effectively with lower intensity outpatient services. Ideally, the length and type of treatment should be individualized based on the offender's assessed needs and responsivity factors (i.e., offenders' level of functioning, mental health issues, etc).

To operate more cost-effectively, attention needs to be given to up-front assessments of risk and responsivity factors and to ways of ensuring that parolees who enter treatment also complete it. The program with the lowest cost that produces the same reduction in reincarceration should be the preferred choice for each classification of offender. For instance, it is a better investment to provide intensive treatment to inmates with drug-related problems who are classified as high-risk for recidivism. Less intense services may be adequate and more efficient for lower risk parolees. *Following the intensive in-prison treatment, residential aftercare is critical for optimizing these resources and achieving positive outcomes.* This emphasizes the need for ways to select and engage offenders in corrections-based treatment settings (Griffith, et al. 1999).

Inciardi and colleagues (1997) have argued that an integrated continuum-of corrections-based TC treatment works best for seriously drug-involved offenders. This continuum involves three stages of TC treatment, tied to an inmate's changing correctional status: prison→work release→parole or other form of community supervision.

The primary stage of treatment should consist of a prison-based TC designed to facilitate the modification of deviant lifestyles and behavior. Inciardi suggests this stage should last 9-12 months and be within 12-15 months of work release eligibility (Martin, et al. 1999).

The secondary stage is a transitional TC, such as a therapeutic community work release center, with a program composition similar to that of a traditional TC. In Pennsylvania, this would equate to release to a Community Corrections Center while continuing to participate in treatment (Martin, et al., 1999).

In the tertiary or aftercare stage, clients have completed work release and are living in the community under parole or some other form of supervision. Treatment intervention in the aftercare stage should involve outpatient counseling and group therapy. Clients are also encouraged to return to the community-based TC for refresher and “booster” sessions, attend group therapy, family sessions and spend one day each month at the community corrections center. *Less than one out of three clients with this type of aftercare have a new arrest, whereas more than two out of three of the comparison groups with no TC treatment have a new arrest* (Martin, et al. 1999).

An example of this three-stage treatment process is replicated by the Kyle Correctional Center in Texas, in their New Vision Intensive In-Prison Therapeutic Community program that has been operational since May 1992. This three-phase program begins with a nine-to-12 month in-prison TC phase, followed by up to three months of residential treatment (community corrections-based treatment) and 12 months of non-residential treatment (aftercare/intensive parole supervision). Progression from each phase is based upon the individual successfully completing each treatment task, learning activities and staff recommendations. The New Vision phase system is a developmental system that represents improvements in the offender’s assumption of personal responsibilities and accomplishment of constructive behavioral changes.

The New Vision program was recently evaluated by the Texas Christian University, which reported that only 25 percent of New Vision graduates who also completed the residential aftercare program were returned to prison within three years, compared to the untreated comparison group, of which 42 percent returned to prison (Livingston, et al. 2001). While evidence suggests that prison treatment alone fails to have a lasting impact, when additional treatment during the community corrections and community aftercare phases is also incorporated, the effects of the multi-phase treatment become more potent and greater success is realized (Martin, et al. 1999).

Although there is some difference of opinion about length of stay in treatment, several studies have indicated that less than 90 days of treatment is not very effective, while other studies reflect unwillingness by participants to continue treatment after 6 months. Still others cite 9-12 months as the optimum length of stay in treatment. That said, it is important to note that not all of this research has specifically evaluated in-prison TCs; rather, they are more generalized outcome studies on drug abuse treatment, which could encompass treatment outside of the prison environment (Devereux, 2001).

For comparison, the following chart reflects length of treatment in two TC programs that have published three-year reincarceration outcomes and have been determined to be successful:

Type of Treatment	Amity (CA)	Kyle-New Vision (TX)
In-Prison TC	Up to 18 months	9-12 months
Community-Based TC	Minimum of 9 months	Up to 3 months
Aftercare	Minimum of 6 months	12 months

The optimal length of treatment is a complex issue because there is no universally agreed-upon standard. First and foremost it must be decided what the program is hoping to accomplish. Is the end goal of the TC to offer another stand-alone program option to offenders? Or will the TC concept be used in a multi-phase process of treatment and planning for the offender’s release back into his or her home community. The literature concludes that program length should be directly related to the intended outcomes of the program.

Again, the ideal treatment program would be responsive to the assessed needs of the offender. Program design should include estimates of the length of time needed to achieve specific treatment goals with allowances for offenders who need additional time (Devereux, 2001). Professional standards support that only clinicians should make clinical decisions. Program assignment decisions should be made primarily on the basis of clinical assessment.

Other issues that surfaced during this literature review included the use of volunteers, training ex-offenders and recovering addicts to be counselors, developing curriculums and cross training of staff. In most of the successful programs, former offenders (clients) volunteer to mentor program participants in the TCs. Many of these former clients pursue advanced training and education to enable them to be hired as permanent counseling staff for the TC. Several programs also noted that they do not have to recruit volunteers because so many community members want to be involved, often in the AA/NA-type meetings held in both the prison and community corrections TC’s.

The development of curricula facilitates the standardization of services across the system. The curriculum would provide guidance for both counselors and offenders in the cognitive, emotional, and behavioral restructuring necessary for successful implementation of the treatment program. Having a comprehensive curriculum is especially important to the TC concept, due to the number of different service providers, as well as the types and physical locations of programs. Another compelling reason for curriculum development is to seamlessly continue the provision of treatment as inmates move from institution to institution or across community settings.

The development and use of a curriculum segues into the issue of cross training staff. Research indicates that there should be coordination and continued training provided for institutional, community corrections center, parole and any other social service provider involved in the program to ensure that the treatment model is understood and taught consistently by the professionals who work with it.

Finally, whatever type of program developed is far more likely to achieve its goals if there is a solid working collaboration between other government agencies and community-based social service organizations. Most importantly, corrections, probation/parole agencies and any other relevant social service agencies should participate in the development of any long-term plan for the statewide implementation of TC programs for substance abuse. A partnership of this type would be able to focus on the ongoing development and improvement of a substance abuse TC treatment program, staff development through combined training and elimination of any duplication of services. Such coordination could result in overall cost savings to all involved parties. A final benefit of this coordinated effort would be a unified front in the ongoing evaluation of the TC program and the ability to implement any revisions to the program deemed necessary based on treatment outcome.

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