

Reentry into the Community after Addiction Treatment within NJ's Prison and Jails

New Jersey Reentry Roundtable

January 24, 2003

Douglas Ziedonis, MD, MPH

Nancy Violette, LCSW, CADC

It is in New Jersey's best interest for prison and jail inmates with substance use disorders to receive appropriate treatment while incarcerated and after release. Addiction treatment is effective and funding this service during reentry is both cost-effective and clinically necessary. Moreover, the failure to address this need in a comprehensive way is not only costly but ultimately decreases public safety and undermines community stability.

**Unfortunately, only about 8 to 12% of NJ inmates receive addiction treatment while incarcerated even though current estimates are that about 80% have substance use disorders (Kline et al, 1999).** National studies clearly show the broad impact of ineffective or unavailable treatment: inmates who relapse to substances upon reentry are much more likely to return to criminal activity. For example, about 66% of untreated heroin addicts first resumed their drug use and then patterns of criminal behavior within three months of their release (Reuter, 1992; CASA, 1998; Federal Bureau of Prisons, 1997). Inmates with substance use disorders are the most likely to be re-incarcerated – - over and over again - and the length of their sentences continually increases. The more prior convictions an individual has, the more likely s/he is to have a substance use disorder. In state prisons nationally, 41% of first offenders have used drugs, compared to 63% of inmates with two prior convictions and 81% of inmates with five or more prior convictions (CASA, 1998). Half of state parole and probation violators were under the influence of drugs, alcohol, or both when they re-offended (SAMHSA, 1998). Even inmates who do engage in and benefit from in-prison treatment are at high risk for relapse if addiction treatment is not part of the reentry process (SAMHSA, 1998).

**Providing substance use disorder treatment to offenders is good public policy. Addiction treatment improves mental and physical health and reduces criminal behavior and recidivism** (Andrews, 1994; SAMHSA, 1998). Improving linkages to addiction treatment during reentry will require changing the way we do business. Thorough assessment, case management, personalized reentry plans for inmates, and team partnerships are critical. Effective models from other states bridge treatment providers in prisons, jails, community corrections, and other institutions, as well as community providers. Ultimately a comprehensive strategy to reduce recidivism must include addressing substance use disorders throughout the criminal justice system, including improved addiction assessments, increasing the number of inmates who receive in-prison addiction treatment, ensuring the quality of the treatment received, and linking to community based aftercare.

This paper reviews what we know about the impact of addiction on the transition from inmate to civilian status. It begins with a description of existing approaches to addressing addiction and reentry in the New Jersey criminal justice system, and the major obstacles to successful reintegration for inmates with substance abuse disorders. It concludes with some short and long-term recommendations for addressing these obstacles and improving how the state responds.

## Current Approaches to Addiction Assessment and Treatment

Inmates with substance use disorders are the expectation not the exception in New Jersey. Most of the about 80% of prison inmates have a history of a substance use disorder are poly-drug abusers, with considerable addiction severity, and have been abusing substances for about 10 years (Kline et al, 1999). NJ inmates with substance use disorders have demographic characteristics and criminal histories similar to those of the prisoner population as a whole (Kline et al, 1999). Most are male (95%), African American (65%), age 21 to 39 (75%), have a high school education (55%), and were never married (80%) (Kline et al, 1999). The primary substances of abuse for NJ inmates are heroin/opiates 36%, cocaine/crack 25%, marijuana 21%, and alcohol 14%. About 52% have both alcohol and drug problems, 6% alcohol only, and 42% drug abuse only (Kline et al, 1999). Nationally and in NJ, except for detoxification, most offenders have not received addiction treatment in the community (Lipton et al., 1989; Peyton, 1994; Kline et al, 1999).

Unfortunately, NJ inmates do not receive comprehensive substance abuse evaluations and the primary assessment tool is only a modified and abbreviated Addiction Severity Index (ASI) assessment. Although the ASI is a useful instrument for determining severity of addiction, the ASI is not a diagnostic instrument that determines the presence or absence of a substance use disorder. Between 1991 and 1998 in NJ, inmates' ASI evaluations determined that 17% have "extreme addiction severity," 53% have "considerable addiction severity," and 20% have "moderate addiction severity" (Kline et al, 1999). These severity ratings evaluate the current need for treatment. More recent data (State Fiscal Year 2001) suggests similar findings with 57% of inmates scoring moderate to extreme severity for current drug abuse and 32% had a moderate to extreme severity for current alcohol problems (Wojtowicz, 2003).

Of the relatively small percentage of inmates who will receive substance abuse services, the system targets inmates with high addiction indices but few mental health concerns. High addiction severity along with parole eligibility within 12 to 30 months is the first screen for in-prison substance abuse treatment eligibility. Lower levels of addiction severity go untreated, creating missed opportunity for earlier intervention amongst the group most likely to respond well to treatment intervention of less intensity. Inmates usually are ineligible for in-prison addiction treatment if they have a co-occurring mental illness, need psychiatric medication treatment, or were incarcerated for sexual assault and arson charges.

The primary approach to addiction treatment in New Jersey's prisons is the therapeutic communities (TCs). There are currently 1,450 beds in TCs at 7 institutions within 12 programs / units. In general, the TC model views drug abuse as a disorder of the entire individual, necessitating a focus on conduct, attitudes, moods, values, and emotional management, with a heavy emphasis on the twelve step self-help philosophy. The TC promotes a culture in which individuals can learn from each other and grow from being a part of a community with the help of peers and para-professionals. The TC model has been demonstrated to be effective (SAMHSA, 2002; DeLeon, 2000). However while TCs offer a milieu for recovery, the prison TC is not

structured to address chronic and multi-tiered problems experienced by this population. The presence of treatment professionals with more advanced training is needed to better prepare inmates for reentry and to address the severity of the addiction and related problems. Prior to reentry some inmates are offered a “continuum of care” step-down to an addiction rehabilitation oriented halfway houses.

On reentry, follow-up case management is crucial but extremely limited. In NJ there are only 26 Intensive Parole Drug Program Officers (IPDPO) who are specialized to manage addiction related issues and will monitor inmates during the re-entry process after the post-incarceration halfway house drug treatment program services.

In NJ, outpatient and residential addiction treatment services are provided through Mutual Agreement Programs (MAPs). The MAPs are supported through a partnership between the DHHS Division of Addiction Services (DAS), the Department of Corrections, and the State Parole Board. This program includes a transfer of about \$4 million to DHSS / DAS to support the purchase of over 200 residential alcohol and drug treatment beds in the community for appropriately assessed inmates and paroled offenders. The MAPS include some outpatient aftercare services, specifically Intensive Outpatient (IOP) treatment for some parolees. IOP treatment means at least nine hours a week of individual or group counseling for only 16 weeks. Most community providers believe that the contract for IOP services is too limiting and does not allow for step-down care (including using existing resources to provide less intensive treatment for a longer time period in a step-down manner).

### **MAJOR OBSTACLES TO SUCCESSFUL REINTEGRATION:**

Inmates with substance abuse problems will be challenged by both the obstacles arising from their addiction disorder and by systemic and structural barriers between the criminal justice system and the community based addiction treatment system. Major concerns are that only a few inmates with substance use disorders receive addiction treatment while incarcerated; the TC model does not adequately prepare inmates for the transition to the community; and there are a limited number of case managers who specialize in addictions. Most inmates with substance abuse histories are not transitioning to community addiction treatment programs upon reentry. Because of the limited treatment modalities involved in the prison Therapeutic Communities, there were missed opportunities for inmates to be better prepared for reentry through the development of specific coping skills that evidence-based psychosocial treatments teach (relapse prevention therapy, etc) and also addiction treatment medications can support (methadone, naltrexone, antabuse, etc).

#### **Addiction-related obstacles:**

The reentry process creates new clinical obstacles that were not present while the inmates were incarcerated. The inmate usually returns, with a criminal record, to an economically depressed community with few prospects for employment, limited transportation to jobs and

resources, and exposure to drug dealers looking to expand their business. Substance abuse relapse is usually linked to exposure to old triggers (people, places, things, and emotional states) in the context of increased substance access and decreased structural boundaries and support. Counselors and clients report that other triggers that induce substance craving and relapse include stress, handling money, idle time, resentments, “defeated thinking,” low self-esteem, facing the stigma of being an ex-convict addict, inability to cope with new frustrations, and feelings of hopelessness and helplessness. These risks are exacerbated by the stresses common to individuals returning home from incarceration, such as lack of housing or employment, and tenuous community, family and social relationships. Many of the inmates with substance use disorders also have serious medical illnesses, such as AIDS and hepatitis C, and/or mental illnesses that can further complicate treatment and the reentry process. Without case management or other supports, inmates often lack the knowledge and / or skills to access available resources that would promote recovery.

Even those who have received treatment inside a correctional facility therapeutic community will still have serious adjustment problems that put them at risk for relapse. They return to the community without the extra protection of appropriate relapse prevention training and addiction treatment medications, and many former prisoners have trouble generalizing the coping skills they did learn in the institutional setting. Since a major part of jail and prison culture is "working the system," some individuals may approach community service providers non-productively, seeking to find a way to take advantage of those seeking to help them. For the majority of inmates who have not received treatment prior to or during incarceration, that lack of treatment will be a serious obstacle both to reentry and future recovery.

### **Systemic Obstacles:**

System obstacles to addressing substance abuse includes limited addiction assessments, poor coordination of sentencing and mandatory addiction treatment, limited discharge planning that is specific to substance abuse, limited addiction treatment within the criminal justice system, limited resources for the transition process, and workforce obstacles. In addition interagency obstacles limit communication, planning and interface between the criminal justice system and the addiction treatment system.

Poor Coordination of Sentencing and Addiction Treatment: The problem of inadequately addressing substance abuse during reentry begins with the sentencing phase. Unfortunately, comprehensive addiction assessments are not often done during the sentencing phase, unless the individual is part of New Jersey’s drug court program. This is one reason why addiction treatment is not structured to fit within the sentence imposed by the court and, therefore sentences do not adequately address the addiction treatment needs of the offender. Sentences are not structured so that comprehensive addiction assessments are ordered, and the defendants are not given recommendations for treatment. Without a qualified addiction assessment prior to

sentencing, treatment can be seen as retribution or punishment. Judges express the need to have better clinical guidance in order to shape the appropriate and specific treatment interventions.

Assessment of addiction is limited and impacts treatment planning and reentry choices: There is a need for better screening and assessment strategies while inmates are incarcerated. Because addiction assessments are limited and not comprehensive, treatment planning during incarceration and the re-entry process has limited information to address the problems of addiction. The discharge planning forms do not have enough substance abuse questions and information to prepare the inmate to manage cues and triggers. The level of ASI severity amongst inmates should be the cue to do more comprehensive addiction assessments. In addition, NJ data on inmates only describes addiction severity as measured by the ASI – not diagnoses. This maintains a lack of clarity on the actual number of substance abusers within the NJ prisons and jails. More accurate information is needed on the rates of substance use disorders amongst inmates and the severity of related problems, including co-occurring mental illness and medical illness. The lack of diagnostic clarity may in fact be one of the reasons that addiction treatment and recovery services are not universally provided throughout the legal system.

Most evidence-based addiction treatments are not provided in the correctional system: Evidence-based addiction psychosocial and medication treatments are not used in the correctional Therapeutic Communities, therefore inmates are not receiving the standard of care that community based addiction treatment programs provide. This limitation is a missed opportunity for inmates to be better prepared for reentry. Psychosocial treatments help enhance motivation, understand triggers to use and how to manage them, and increased understanding of how to manage stress, anxiety, depression, and interpersonal difficulties. Addiction treatment medications (methadone, naltrexone, antabuse, etc) are another evidence-based clinical tool that can ensure abstinence through pharmacology creating a “drug free environment” even within the community setting. Psychiatric medications are appropriate for inmates with co-occurring addiction and mental illness and are also underutilized. Obstacles to integrating these approaches include limited resources, few staff trained in these modalities, the lack of medical staff working in the TCs, the division in corrections between addiction and mental health services, and the historical anti-medication roots of the Therapeutic Community model.

Mental health treatment services are separate from substance abuse treatment services: The disconnect between mental health and addiction treatment services obviously inhibits appropriate co-occurring mental illness and addiction disorder treatment while incarcerated, and this disconnect also impacts reentry referrals and treatment planning. In addition, because of limited resources only the mental health system has the medical services needed to provide specific medication treatments. This inhibits inmates in the correctional TCs to have less severe mental illnesses addressed appropriately, including mild to moderate depression, post-traumatic stress disorder, learning disabilities, cognitive impairment, and personality disorders.

Few case managers, especially those with addiction training and experience: There are very limited resources for case management dedicated to helping the parolee. Parole officers have extremely large caseloads, and very few (26) have addiction specific knowledge and skills. Resources are earmarked for either institutional or community services, but limited funding supports the case management to help during the transition process. The MAP service is a good idea but is very limited in amount of funding relative to the extent of the problem, and this program does not provide adequate case management services and outpatient treatment. Existing outpatient treatment is limited to 12 weeks of Intensive Outpatient Services and does not allow for flexibility in modifying these resources to allow for a longer treatment period at a step-down level of outpatient care.

Other Interagency Coordination Obstacles: In general there is a lack of system coordination between the addiction treatment providers and the criminal justice system staff. The individuals work within different systems and there are unclear lines of authority and responsibility. The CJS and community based addiction treatment providers operate under separate funding streams, with differing missions, different perspectives about client confidentiality, and different philosophical orientations toward public safety and offender rehabilitation. This fragmentation inhibits transfer of information about the offender and results in duplication of some services (such as assessment), and a gap in the continuity of other services (such as case management and treatment service delivery). Legal issues, particularly confidentiality, may keep information out of some transition team members' hands. Unfortunately, the gaps in information lead to a lack of accountability for the offender upon release or transfer.

Both the criminal justice and treatment systems need as much information as possible about an individual in order to ensure continuity of care; each should take advantage of the increased technical capabilities for automated information systems. As the number of substance-using offenders escalates, and health and social service systems become increasingly complex, interagency linkages between correctional, health, and substance use disorder treatment systems become increasingly critical. Significant differences in philosophy and approach between treatment settings in the CJS and in the community can make transition to community treatment difficult. Offender clients who are newly released from incarceration may be seen as non-compliant, when they are actually confused about expectations and requirements of the new setting. Individuals with “triple diagnosis” (medical, mental health, and addiction) have even more system barriers, including stigma, separate and inadequate funding streams, and professional norms that differ among programs serving these populations.

Lack of Attention to Offender Issues by the Addiction Treatment System: Within most community addiction treatment programs there are few staff with specialized knowledge and skills about the correctional system or the unique needs of offenders. Offenders often present to addiction treatment programs reporting long periods of forced abstinence due to incarceration and low motivation to actively participated in ongoing addiction treatment. This is a different type of client for most addiction treatment counselors. Different clinical skills are required. Most of the

visible statewide planning by the NJ Governor's Council on Alcoholism and Drug Abuse and the DHHS Division of Addiction Services appears to be limited in regards to the criminal justice system. In spite of good intentions, this topic receives limited focus by a relatively small number of specialists.

### **OPTIONS FOR ADDRESSING THE OBSTACLES:**

Substance Abuse assessment and treatment are critical components for developing NJRR's reentry strategy. This section of the report suggests specific recommendations for inclusion in the strategic planning process. The first recommendation is to create a Governor's Task Force on Reentry. We believe this would be a critical component for long-lasting change, to address interagency difficulties, legal issues, and fiscal issues. Subsequent recommendations do not rely on the creation of the Task Force and include both short term and longer term recommendations that Departments could initiate on their own or with other Departments and community agencies.

### **Recommendation #1: Create a Governor's Task Force on Re-entry into the Community**

Given the importance of having the NJ State Departments work together and the current fiscal situation in the state of NJ, the Governor's strong endorsement of this strategic planning process is important, including getting the Governor's early support and buy-in. The Governor's support is also crucial for getting buy-in from relevant private partnerships and making this a statewide strategy with likelihood to be implemented.

### **Appendix One of this paper provides a summary of the roles of the 10 NJ State Departments and what are the specific Addiction Related Activities and Responsibilities.**

A Governor's Task Force has a unique opportunity to address interagency coordination obstacles and better integrate the various systems. The offender's problems are currently the responsibility of both the corrections and addiction services systems, and the offender's success benefits both systems. The Task Force can ensure that planning is more likely to be statewide and maintains a cross-system criminal justice & substance use disorder treatment planning body. A Governor's Task Force is crucial to improve the reentry process because only the state government can define who is in charge of the transition process and create policies dictating the process by which transitional issues are addressed. The state also determines the funding levels and requirements for funding substance use disorder treatment and specifies annual appropriation needs, including specify treatment resources such as residential and substance use disorder programs dedicated to offenders leaving institutional care.



A Governor's Task Force can create unique opportunities to educate the legislature on the reentry process and the critical funding issues. This education can include the necessity for case management, substance abuse treatment, and other reentry services; help develop new legislation; and identify the need for changes in existing legislation which present obstacles to successful offender transition.

An effective NJ statewide plan for addiction prevention and treatment services has not been created and implemented because of a lack of strong support and commitment from the Governor for any one group to take the lead on this task. On paper NJ does have a Governor's Council on Alcoholism and Drug Abuse (GCADA), however GCADA has very limited resources to develop a statewide strategic plan and most importantly has not received strong gubernatorial support. The recent major initiative of the DHHS Task Force on Addictions focused primarily on the community based addiction treatment services, and the current DAS' Advisory Committee on Quality Standards for Addiction Treatment continues to have limited attention directed towards the reentry issue and other links with the criminal justice system.

**Connecticut is a model state for demonstrating the effectiveness of a Governor's Task Force on Addiction Services.** Connecticut is one state among others that have utilized the Governor's Task Force model to effectively address topics that transcend Departmental organizational and policy boundaries. The CT Governor's Task Force on Addictions brought together all of the CT State departments and a range of private agencies. *The strategic plan for CT had its recommendations organized as a business plan (product, strategy, timetable, new costs, and return on investment).* The Governor's Task Force was very effective and this led to the creation of the CT Alcohol and Drug Policy Council to continue the initial efforts of the Governor's Task Force. The Council is authorized to develop the statewide addiction plan and has been supported for most of its recommendations. The Council focuses on the Prevention, Treatment, and the Criminal Justice Systems.

The CT Criminal Justice Work Group has identified four major areas (Connecticut Alcohol and Drug Policy Council, 2002):

1. Expand the use of substance abuse treatment and other alternatives to incarceration by increasing the capacity of programs and expand the use of probation officers to ensure necessary supervision and support.
2. Increase substance abuse treatment capacity for all incarcerated offenders and promote offender community reintegration and aftercare through improved discharge planning and treatment coordination.
3. Study the non-violent incarcerated population to develop new programs and services to reduce incarceration rates and increase community release with appropriate supervision.
4. Expand substance abuse treatment to provide the necessary care for court involved and Families with Service Needs children and youth.

The Governor's Task Force on Reentry planning process and Committee membership should include representation from both the private and public sector. Relevant stakeholders include criminal justice system, addiction services, Addiction Treatment Providers and other community agencies, support services, business leaders & employers, treatment providers, schools & Universities, medical community, faith community, voluntary organizations, media, advertising industry, sports organizations, law enforcement & regulatory agencies, legislatures, community & regional government, insurance industry, academia, families, consumers, etc. The Plan should emphasize possibilities for linkages across departments and integrate private and community activities and organizations.

### **SHORT-TERM RECOMMENDATIONS:**

#### **Recommendation # 2: Improve Substance Abuse Assessments of Inmates at Baseline, throughout the incarceration period, and especially 3 to 6 months prior to reentry**

Given that a substance use disorder should be the expectation in service planning for inmates, all inmates should receive comprehensive addiction and mental health assessments, including assessment of their motivation to remain abstinent upon reentry. In the community, assessment usually begins the treatment process of forming a therapeutic relationship, bringing problems into the open, discussing treatment options, and setting treatment limits. Eventually a similar process should also be true for the criminal justice system, however this would require that some type of treatment be part of the process. Individuals with lower severity addiction problems present another opportunity to address substance use disorders.

A comprehensive assessment to assist in transition planning should include standardized, comprehensive addiction risk and needs assessment tools appropriate to the offender populations. The assessments should include multiple assessments and examine treatment needs, treatment readiness, treatment planning, treatment progress, and treatment outcome. Ideally a multidisciplinary team would conduct the risk and needs assessments. Areas to be assessed include skills for daily living, stress management skills, general psychosocial skills, emotional readiness for the transition, literacy, and money management abilities. Criminal justice staff can contribute critical information on risk and dangerousness. Assessment results should follow the offender through the systems (SAMHSA, 1998).

#### **Recommendation # 3: Develop individualized reentry plans that include addressing substance abuse relapse prevention & other important addiction treatment issues in the discharge planning**

(SEE APPENDIX TWO)

**a. Put relapse prevention and other substance abuse information (see examples in Appendix Two) into the current personalized reentry plan for everyone being released from state custody.** An individualized relapse prevention plan should be developed for each offender. It is often developed as a standard form, written in simple, non-clinical language, with a checklist of behavioral indicators that help predict the potential for relapse. All parties should use the plan: the offender, treatment agency, supervising officer, and others.

**b. A working group from DOC and DAS should be organized to review the current reentry plan and do chart reviews of some existing files.** The reentry plan should include issues such as identification documents, temporary and permanent housing, medical care and treatment, substance abuse and mental health treatment, financial support and employment, and family support.

**c. An Addiction Services Referral Form and Process from the correctional facilities should be created** that specifies treatment appointments, frequency of meetings with the parole officer, frequency of urine tests, and vocational expectations, so that all requirements and goals are stated in one written agreement.

**Recommendation # 4: Enhance case management services by increasing funding for this service, training parole officers on addiction treatment issues, and by creating an Integrated Transitional Services Approach to the Case Management Efforts**

**a. More Parole Officers are needed and they need to understand addiction treatment issues and resources.** Offenders released from incarceration face a significant challenge in transitioning to successful community living. Re-establishing a life in the community is difficult. Establishing a recovery lifestyle, perhaps for the first time, is often overwhelming. Most offenders return to the same environments from which they came where they used substances and committed crimes. While treatment in prison can give people new skills and insights the task of implementing those new skills in an old environment is extremely challenging. Parole Officers serve an important role in the process of reentry for the offender.

***b. Using an integrated case management model can help to monitor and follow the inmate's progress in all areas.*** To achieve the system collaboration and services integration required for most cases, staff from in-prison, parole, and addiction treatment agencies must reach beyond traditional roles and service boundaries by brokering services across systems, sharing information, and encouraging treatment.

The NJ PACT team model is used to provide a multi-disciplinary team approach to case management and linking residential services and outpatient services. This team approach could also adapt to the different individual needs of offenders and the different needs during different time periods of reintegration into the community. The PACT model approach includes that the staff will provide housing advocacy, transportation, vocational linkages, a buddy system, and linkages to mental health, family services, substance abuse and medical care treatment services.

There are several other program models used nationally to provide transitional services for offenders being released: *outreach*, *reach-in*, and *third party* (SAMHSA, 1998). We concur with the SAMHSA conclusion that an integrated or mixed model approach is the best option. The integrated model includes aspects of all three models. In this approach the correctional institution designates staff to make linkages to appropriate services in the community and the community programs have the opportunity to conduct assessments and make recommendations to the corrections staff concerning the offender's needs (even if reach-in occurs by telephone case conferences). This could be put into operation by creating case managers both within corrections and the community who work together as a combined “exit and entry” team. Sometimes contracting with a third-party entity to coordinate some of the transitional services can be also a helpful component. Other states have found that the integrated model provides opportunities for effective collaboration and more readily unites systems because they are forming an alliance to reach mutual goals (SAMHSA, 1998). Critical service needs are more easily identified, and the offender has a better opportunity to become engaged in community treatment. Additionally, the integrated model allows systems to be more responsive to critical incidents, because monitoring and surveillance are more coordinated, there is better communication across systems, and sanctions are developed and enforced by both the criminal justice and addiction treatment agencies.

**c. Increase training for all parole officers on both addiction and mental health treatment and referral issues.** Having only 26 parole officers with specialized addiction training in NJ does not adequately address the problem. All current parole officers should receive additional training.

**Recommendation #5: Improve the quality of addiction services within the correctional institutions and community agencies to help offenders during the pre-reentry and reentry process:**

**a. Increase the scope of the current Division of Addiction Services’ Advisory Committee on Quality Standards for Addiction Treatment to focus on improving the quality of addiction services in preparation for reentry both within the correctional**

**institutions and within community agencies.** Currently there is very limited focus on the reentry issue within the Division of Addiction Service's Advisory Committee. Dr. Ziedonis is the chair of this Advisory Committee and there is room to increase the focus on this attention with an agreed upon mandate by the leadership within the Department of Corrections and the Division of Addiction Services. Additional members to the group from the criminal justice system should be included on the Advisory Committee. The Committee will make recommendations for clinical standards, thresholds, and other clinical expectations, including the use of evidence-based addiction psychosocial and medication treatments.

The MAP contract with community addiction treatment providers (Attachment C) should be reviewed by the Advisory Committee to assess what works well and what needs improvement. The Advisory Committee or another group should describe the current Continuum of Care for Addiction Services for individuals throughout the Criminal Justice System and make recommendations for enhancing the system. The Advisory Committee could suggest quality standards for the corrections TCs.

**b. Pre-reentry and Reentry Program Development is needed, including staff training in corrections and in community agencies.** Community treatment providers working with offenders should receive education about the prison environment and structure, offenders with substance use disorders, and the criminal justice system in general.

**c. More staff with additional training and experience in addiction treatment (MSWs, CADCs) need to be hired within corrections to implement the psychosocial treatments.** Psychosocial treatments help enhance motivation, understand triggers to use and how to manage them, and increased understanding of how to manage stress, anxiety, depression, and interpersonal difficulties. Addiction Treatment Programs need to recruit and develop staff with special expertise treating offenders.

**d. Medical staffs are needed in the corrections addiction treatment system** to prescribe addiction treatment medications (methadone, naltrexone, antabuse, etc) and appropriate psychiatric medications for co-occurring addiction and mental illness.

**e. Ongoing outcomes research that links DAS and DOC databases are needed to do ongoing evaluations and quality improvement.**

**Recommendation #6: Increase Academic Partnerships on the issue of reentry and the addiction treatment and research communities**

Academic Partnerships can be very effective mechanisms to provide staff training, improve quality services, do outcomes research, and bring new federal and Foundation funds to NJ on this topic. New academic partnerships on topic of reentry could include representatives from leading NJ Academic Programs such as the Addiction Consortium (Rutgers University

Center for Alcohol Studies, UMDNJ Division of Addiction Psychiatry, and UMDNJ University Behavioral Health Care), Princeton University, and other academic groups. Academic partnerships can help with the needed broad public education around these goals geared towards public officials, the media, and the public at large. Academic Partnerships could include training on evidence-based interventions, including medications and psychosocial treatments.

**Recommendation # 7: Use the “Going Home” Re-entry Grant as an opportunity to test the enhancement of addiction and mental health assessment, multi-disciplinary multi-specialty transition team development, and linkages with addiction treatment services.**

The “Going Home” Re-entry Grant is an opportunity to develop and test the enhancement of addiction and mental health assessment, multi-disciplinary multi-specialty transition team development, and linkages with addiction treatment services. This is a unique opportunity to begin the process of implementation of some of the other suggestions.

**LONG TERM RECOMMENDATIONS:**

**Recommendation #8 Provide adequate funding for substance abuse treatment for all inmates throughout the whole Criminal Justice System.**

All inmates with a substance use disorder should be provided the opportunity for treatment. **Addiction treatment for offenders while incarcerated and during re-entry is cost effective. Recidivism is reduced.** Ongoing involvement in substance use disorder treatment is associated with decreased rates of re-arrest, conviction, re-incarceration, and time to recidivate (Field, 1995a; Inciardi, 1996; Peters et al., 1993; Swartz et al., 1996; Wexler et al., 1990). The CALDATA study found that recidivism rates for individuals who received substance abuse treatment in prison was reduced to 42% versus 63% with no treatment. Further, if prison treatment was then followed by a residential placement of four months the rate decreased to 26%. Prerelease therapeutic communities have shown high rates of success among inmates studied (Wexler et al., 1988; Field, 1989). Involvement in substance use disorder treatment is associated with decreased substance use and relapse and other health-related outcomes (Inciardi, 1996; Martin et al., 1995; Wexler et al., 1990).

The duration of correctional substance use disorder treatment is associated with positive treatment outcomes. Research has shown that longer lengths of treatment are more effective than shorter lengths of treatment for substance-using offenders (Swartz et al., 1996; Wexler et al., 1992). Involvement in substance use disorder treatment, such as prison-based therapeutic communities, is associated with successful parole outcomes including reductions in parole violations (Field, 1989; Wexler et al., 1992).

### **Recommendation # 9: Improve Coordination of Sentencing and Addiction Treatment.**

Whenever possible, addiction treatment should be structured to fit within the sentence imposed by the court and, conversely, sentences should be structured to accommodate the addiction treatment needs of the offender. Sentences can be structured so that comprehensive addiction assessments are ordered, and the defendant must follow the recommendations for treatment. Prior to any treatment mandate, the court should receive the results of a thorough substance use disorder assessment of the offender, performed by a qualified professional. Mandating treatment without such a qualified assessment may be seen (understandably) as retribution or punishment. Judges will also need clinical guidance in order to shape the appropriate and specific treatment interventions (SAMHSA, 1998).

### **Recommendation # 10: Merge the Mental Health and Addiction Services within Correctional Settings**

Merging the mental health and addiction services will better address co-occurring disorders treatment and increases the number of staff with advanced degrees working in addiction services also will help in cross-training and with better meeting the clients needs.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a great resource for NJ to better address co-occurring disorders during the reentry process. The Center was created in 1995 as a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS). In addition, the Office of Juvenile Justice and Delinquency Prevention, the Office of Justice Programs and the National Institute of Corrections serve as partners. The GAINS Center produced "A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-occurring Disorders: The APIC Model." The GAINS Center can be contacted by 1-800-311-GAIN or the web site [www.gainsctr.com](http://www.gainsctr.com).

Information from the GAINS Center reveals that Therapeutic Community models have been adapted to effectively address co-occurring disorders. The key modifications from the formal TC include increased flexibility, decreased intensity, and greater treatment individuation. Activities are adapted in response to the individual's co-occurring disorder, cognitive impairments, and levels of functioning (Sacks, 2000; SASMHSA, in press). Evaluations of the Modified TC approach have demonstrated positive outcomes for drug use and employment, psychological functioning, and involvement in criminal activity (Sacks, 2001; SAMHSA, 2002).

### **Recommendation #11: Increased Family involvement with Reentry and Addiction Treatment**

Many offenders do not have intact or available families, and many offenders' families pose a risk for substance use or recidivism. Nevertheless, if they can provide positive support for the goals of the treatment, family members should be involved in the assessment, planning, and treatment of transitioning offenders.

Ideally, family education efforts should occur before the release of the offender. Significant others and family members should receive information about what to expect when the offender makes the transition to the community. They should also understand the nature of the treatment program in the incarcerated setting, the substance use disorder, the transition plan, and resources for the offender and the family. If appropriate, family members may be asked to provide collateral information about the offender's situation, but offenders should always be asked if they want their families involved in their treatment and give formal consent. If assessment and treatment planning meetings are conducted in residential treatment or halfway houses, family members can sometimes participate in meetings and meet with parole officers. To be a positive support for the offender and to participate in the reintegration process, family members may benefit from social and self-help resources, such as Al-Anon and Toughlove groups. Another support group is Prison Families Anonymous, for families with members who have been involved in the corrections system. This valuable resource can address such issues as guilt, responsibility, owning one's behavior, detachment, and control. This group also has a referral service to help families locate other resources (SAMHSA, 1998).

### **Recommendation #12: Address issues of Confidentiality between the Criminal Justice System and the Addiction Treatment System**

All staff members involved with transitional services need training on the parameters of client confidentiality. Client confidentiality and the offender's right to privacy must be balanced against the needs of various agencies for information. The extent of computerization and the security of client data across agencies are areas of crucial concern in partnerships between various transitional services. During the planning process for information sharing, these issues should be addressed in great depth. It is essential for the administrator charged with managing a transitional services program both to understand confidentiality regulations and to work out methods by which clients are informed of their rights.



## **Bibliography:**

Andrews, D.A.

An Overview of Treatment Effectiveness: Research and Clinical Principles. Ottawa: Carleton University Department of Psychology, 1994.

Center for Substance Abuse Treatment.

Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse – Second Edition. Treatment Improvement Protocol (TIP) Series. Washington, DC: U.S. Government Printing Office, in press.

Connecticut Alcohol and Drug Policy Council.

Statewide Interagency Substance Abuse Plan. State of CT. Hartford, CT. 2002.

DeLeon, G.

The Therapeutic Community: Theory, Model, and Method. Springer Publishing Company, Inc. New York. 2000.

De Leon, George; Sacks, Stanley; Wexler, Harry K.

Modified prison therapeutic communities for the dual- and multiple-diagnosed offender. Leukefeld, Carl G. (Ed); Tims, Frank (Ed); et al. (2002). Treatment of drug offenders: Policies and issues. (pp. 138-148). New York, NY, US: Springer Publishing Co. xiv, 453pp.

Federal Bureau of Prisons.

Quick Facts. Washington, DC: Federal Bureau of Prisons, May 1997.

Field, G.

The effects of intensive treatment on reducing the criminal recidivism of addicted offenders. Federal Probation 53(10):51-56, 1989.

Field, G.

"Turning Point alcohol and drug program (women's unit) outcome study. Addendum No. 1." Unpublished report, January 1995a.

French, Michael T; McCollister, Kathryn E; Sacks, Stanley; McKendrick, Karen; De Leon, George.

Benefit--cost analysis of a modified therapeutic community for mentally ill chemical abusers. Evaluation & Program Planning. Vol 25(2) May 2002, 137-148.

Gerstein, D.R.; Johnson, R.A.; Harwood, H.J.; Fountain, D.; Suter, N.; and Malloy, K.

Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA). Sacramento, CA: California Department of Alcohol and Drug Programs, 1994.

Inciardi, J.A.

A corrections-based continuum of effective drug abuse treatment. National Institute of Justice Research Preview, June 1996.

Kline A, Ryan J, and Rodriguez.

Substance Abuse Treatment and Criminal Offenders: Treatment Access and Outcomes of Substance Abusers in New Jersey State Prisons. NJDHHS Research & Information Services Document. December 1999.

Lipton, D.S.; Maroles, E.; and Goldsmith, D.S.

Pathways Into Treatment: A Study of the Drug Treatment Entry Process. New York: Narcotic and Drug Research, Inc., 1989.

Martin, S.S.; Butzin, C.A.; and Inciardi, J.A.

Assessment of a multistage therapeutic community for drug-involved offenders. *Journal of Psychoactive Drugs* 27(1):109-116, 1995.

National Center on Addiction and Substance Abuse at Columbia University (CASA).

Behind Bars: Substance Abuse and America's Prison Population. New York: CASA, 1998.

Peters, R.H., and Hills, H.A.

Inmates with co-occurring substance abuse and mental health disorders. In: Steadman, H.J., and Cocozza, J.J., eds. *Providing Services for Offenders with Mental Illness and Related Disorders in Prisons*. Washington, DC: The National Coalition for the Mentally Ill in the Criminal Justice System, 1993.

Peyton, E.

A Coordinated Approach to Managing the Drug Involved Offender. Wilmington, DE: Delaware Sentencing Accountability Commission, 1994.

Reuter, P.

Hawks Ascendant: The Punitive Trend of American Drug Policy. Santa Monica, CA: RAND Corp., 1992.

Sacks S

Co-occurring mental & substance abuse disorders-Promising approaches and research issues. *Journal of Substance Use & Misuse* 2000: 35(12-14) 2061-2093.

SAMHSA.

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community Treatment Improvement Protocol (TIP) Series 30. DHHS. PHS. SAMHSA. CSAT. Rockville, MD DHHS Publication No. (SMA) 98-3245. 1998.

SAMHSA

Report To Congress On The Prevention And Treatment Of Co-Occurring Substance Abuse Disorders And Mental Disorders Substance Abuse And Mental Health Services Administration U.S. Department Of Health And Human Services. Rockville, MD. 2002.

Swartz, J.A.; Lurigo, A.J.; and Slomka, S.A.

The impact of IMPACT: An assessment of the effectiveness of a jail-based treatment program. *Crime and Delinquency* 42(4):553-573, 1996.

Wexler, H.K.; Falkin, G.P.; and Lipton, D.S.

"A model prison rehabilitation program: An Evaluation of the Stay'N Out therapeutic community." A final report to the National Institute on Drug Abuse, August 31, 1988. New York: Narcotic and Drug Research, Inc.

Wexler, H.K.; Falkin, G.P.; and Lipton, D.S.

Outcome evaluation of a prison therapeutic community for substance abuse treatment. *Criminal Justice and Behavior* 17(1):71-92, 1990.

Wexler, H.K.; Falkin, G.P.; Lipton, D.S.; and Rosenblum, A.B.

Outcome evaluation of a prison therapeutic community for substance abuse treatment. In: Leukefeld, C.G., and Tims, F.M., eds. *Drug Abuse Treatment in Prisons and Jails*. National Institute on Drug Abuse Research Monograph, Number 118. NTIS Pub. No. 93-102143/LL(A14). Rockville, MD: National Institute on Drug Abuse, 1992. pp. 156-175.

Wojtowics J.

Personal Communication. January 2003.

