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A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody

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James K. Stewart
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U.S. Department of Justice
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A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody

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Issues and Practices in Criminal Justice is a publication of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion in the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

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Introduction

Despite the demonstrated relationships between drug abuse and crime, criminal justice agencies too seldom focus on reducing drug abuse as a means of reducing the criminal activities of drug-involved offenders. Yet evidence from the research literature continues to accumulate, indicating that some drug treatment programs have been successful in reducing recidivism. Following an overview of pertinent research findings, this paper outlines the elements of an effective strategy for treating cocaine and heroin abusing offenders.

The interventions proposed in this paper grow out of the drug abuse research literature, the authors' urban-based research, and their clinical experience with drug abuse treatment in corrections. In addition, the suggested interventions emerge from years of correctional outcome research which has assessed what works, with whom, and under what circumstances. Although this paper will focus on heroin and cocaine involved offenders, some recommendations may apply to offenders who use other illicit drugs.

Research findings

The problem

Recent research provides ample evidence that offender populations are composed of large numbers of drug abusers—and that drug-involved offenders commit substantial numbers of undetected crimes.

Very recent cocaine and heroin abusers constitute a majority of the arrestees and inmates in jails and prisons in New York City and some other jurisdictions.

National surveys of jail and prison populations, smaller self-report studies, and urine testing results indicate that increasing proportions of offenders are users of drugs and that cocaine use is increasing the most rapidly. More than three-quarters of the nation's inmates and almost all inmates in New York City report illicit drug use.[1] Similarly, self-report studies among prison and jail inmates in California, Michigan, and Texas reveal that approximately half are heroin users and many are daily heroin users.[2] Recent urinalysis-based studies of arrestees in Washington, D.C. reveal that well over half test positive for at least one illicit drug and a quarter test positive for two or more illicit drugs.[3] In a recent Manhattan study the level of cocaine use had doubled since 1984. Eighty-three percent of arrestees in September and October 1986 tested positive for cocaine, compared with 42 percent in 1984; the increase in cocaine was found at all age levels and for all offenses.[4] Comparable increases have also been reported in Washington, D.C.[5]

Frequent users of heroin and cocaine in the general population exhibit a multiproblem lifestyle that may include a pattern of persistent criminal behavior.

Drug addiction is a chronic relapsing condition that is part of a complex multiproblem lifestyle which is highly resistant to rehabilitation. Several studies show that daily or near daily heroin users—many of whom also use other illicit substances daily—are not in treatment, and do not seek treatment. Many also consume alcohol heavily. They average over 200 non-drug crimes and hundreds of drug distribution offenses annually, yet are unlikely to be arrested more than once a year, and then spend less than a month in incarceration. The majority commit many crimes for which they are not arrested or incarcerated, but because of sheer volume of activity, they still have many more arrests and incarceration periods than non-drug offenders. Over half their generally modest income comes from drug distribution activities. They usually spend most of that income on drugs. Daily heroin abusers also generally do not have a residence nor make their own meals, but rather stay and eat with a relative or friend. They do not receive or seek public assistance. They have no legal employment during a typical week nor do they seek any. Thus, they are typically an economic burden on

the poorest members of their low-income communities. Many aspects of their lifestyle also put them at high risk for violence and many other social and health problems such as AIDS, alcoholism, and TB. Therefore, whatever treatment programming is applied to this population, it must contend with all or most of these problems if it is to achieve long-term changes in this lifestyle.[6]

Data about chronic cocaine users' crime rates are not as well developed. Recent evidence from street and treatment setting interviews with crack users indicate that about 60 percent admit paying for their cocaine with money derived from illicit sources—ranging from drug dealing and prostitution to theft and robbery. The persons using cocaine, however, generally come from more varied socioeconomic backgrounds than heroin users, their lifestyles vary accordingly, and many do not ever get arrested. Nevertheless, the lifestyles of cocaine abusers who do become involved with the criminal justice system appear to be very similar to those of heroin abusers, as cocaine users often also use heroin.[7]

The criminal justice response

While much remains to be learned about the precise nature of the links between doing drugs and doing crime, the two behaviors are clearly associated. Yet criminal justice agencies have few strategies for routinely detecting and intervening in the drug use of arrested heroin and cocaine abusers. The justice system focuses almost exclusively on its criminal processing functions of arrest, adjudication, probation, incarceration, and parole. Even these interventions often represent a limited intrusion on the criminal activities of the drug abusing offender.

Criminal justice agencies, with rare exceptions, do not seek or use information about the drug use of persons who are arrested or convicted of crimes.

Little effort is made to identify drug abusers, to record information about their drug use, to provide treatment (other than detoxification) while in jail or prison, to refer them to treatment programs in the community, or to use such information in plea bargaining or case dispositions (where legally appropriate). Only a few jurisdictions maintain any information about the drug use of arrestees or convicted offenders, and there is a strong likelihood that the drug information in their records is both incomplete and inaccurate because it is most often based on self-report and not substantiated through urinalysis. Thus, information that could help inform criminal justice processing is not generally available.[8]

To the extent that criminal sanctions are applied, their ability to interrupt the life style of the vast majority of cocaine-heroin abusers is minimal.

Nationally, only a low percentage (less than 10 percent) of all felony arrests lead to a felony conviction resulting in incarceration. Over half of all felony arrests (60 percent in Manhattan) lead to conviction, but there is much variation by jurisdiction. Typically, offenders plead guilty to lesser charges

and are sentenced to time served, a fine, community service, probation, or a few months in jail. Consequently, the vast majority of offenders, mainly those arrested on less severe felony and misdemeanor charges, are at liberty within three months after arrest. In addition, many felony offenders (a significant portion of whom are involved with drugs) are at liberty on bail or on personal recognizance while awaiting trial. Active heroin-cocaine users have higher failure-to-appear rates and much higher rates of rearrest while out on bail than offenders not involved with drugs.[9]

The efficacy of criminal sanctions

Little evidence is available that criminal justice sanctions alone are as effective as drug treatment in reducing the drug use and criminality of cocaine-heroin abusers at liberty. The central value of the criminal process may lie in the leverage that can be exerted to bring hardcore drug abusers into treatment.

Existing evidence does not show that criminal justice sanctions (fine, probation, or parole, or length of time served) reduce criminality or drug use more effectively than drug treatment among cocaine-heroin abusers.

It is not known whether or to what extent jail or prison time alone suppresses post-incarceration criminality or cocaine-heroin abuse among drug involved offenders. The limited evidence available suggests that two-thirds or more of arrested heroin abusers return to heroin-cocaine use and their diverse criminal patterns within three months after release from detention. In contrast, several studies of drug treatment outcomes with criminal justice clients (mainly probationers) show substantial post-treatment reductions in both drug use and criminality.[10] Outpatient clients in methadone treatment report less than half as much criminal activity as heroin abusers not in treatment. Compared with their pretreatment criminality, methadone clients report 50 to 80 percent less crime during treatment.[11] Even among those who continue criminal activity during treatment, methadone clients report reduced involvement in serious crimes such as robbery, burglary, or dealing of heroin or cocaine; they report mainly low-level property crimes, con games, and sale of marijuana or pills.[12]

Residential drug programs have sizable proportions (frequently over half) of clients who are on probation or parole or under related legal pressure, and whose criminality is near zero while in the residential program. This near-zero criminality of cocaine-heroin abusers while in residential programs is documented for therapeutic communities in several cities. A study of treatment facilities in New York found that about a third of residential clients were criminal justice referrals and had extensive criminal histories. These clients tended to stay longer and have as good or better outcomes than clients with similar pretreatment criminal and drug abuse histories who were not referred by the criminal justice system.[13]

The coercive power, surveillance potential, and time offered through criminal justice sanctions, open significant opportunities for effectively treating cocaine-heroin abusers.

Although criminal justice sanctions alone may have uncertain value in reducing the criminality of drug involved offenders, those sanctions can serve a powerful role by facilitating effective drug treatment. There are a variety of pressures that bring hardcore drug abusers into treatment: parents, employers, loved ones, and friends may all apply psychological and social pressures. The most powerful pressure, however, may be the threat of legal sanction—the threat of arrest and conviction, and most importantly, the threat of incarceration. The leverage created by this threat, and by the sanction itself, permits treatment to be considered as a viable option by serious abusers. Moreover, by reducing early program termination, it allows the treatment and aftercare to continue for the length of the permissible custody.

Cocaine-heroin abusers typically wish to avoid the "hassles" associated with changing their lives. When the alternative is lengthy incarceration, cocaine-heroin abusers may be more willing to be referred to drug treatment. If, however, the alternative is a short jail sentence, detainees and jail inmates may prefer the incarceration rather than diversion to long-term drug abuse treatment.

Unfortunately, relatively few arrested offenders voluntarily seek treatment.[14] Many offenders are referred by the criminal justice system to drug treatment as the result of negotiated plea bargains in which the offender agrees to enter treatment instead of receiving a substantial sentence. For many years, TASC (Treatment Alternatives to Street Crime) has operated in selected jurisdictions to recruit clients and negotiate with court staff for release of offenders to drug programs. TASC clients are more likely to select treatment because the alternative is considered more onerous.

Few cocaine-heroin abusers in custody volunteer for drug treatment unless the treatment program is seen as an attractive alternative. Prison inmates seek out in-house treatment programs because they often provide better living conditions, a safer environment, parole release considerations, and an opportunity to possibly change one's lifestyle. In-prison programs that offer such conditions are substantially better able to recruit participants than those which do not. Although these offenders may not be completely sincere at admission, there is an opportunity for the program to engage them in an effective treatment experience. In short, the threat of substantial sanctions (for arrestees) or the promise of better in-prison conditions (for those in custody) can operate as extremely useful incentives for treatment. Nevertheless, it must be understood that a significant proportion of offenders who have long chronic heroin or cocaine abuse patterns will not want treatment under any circumstances.

Some dimensions of effective drug abuse treatment

As the preceding section has demonstrated, the criminality of heroin abusers is substantially reduced while they are receiving some form of treatment. The experiences of effective programs suggest that whatever treatment method is used must have a sound theoretical and empirical basis for its implementation. Additionally, the treatment method must emerge from a

powerful social restoration tradition (discussed further below) that is capable of teaching offenders to interact with others in less deviant, more socially acceptable ways. Such an approach must be credible to participants and not be perceived to be coercive and authoritarian. The approach must have the capability to convince offenders that the demanding path to a socially acceptable lifestyle is worthwhile despite their deprived backgrounds, their experience with quick criminal profits, and their recognition that there is a low probability they will be caught for their crimes.

Despite the often cited conclusion that "nothing works", evidence from the research literature continues to accumulate that some programs have been successful in reducing recidivism.[15]

The majority of successful programs have been based on a social learning theory of criminal behavior.[16] According to this theory, criminal behavior is learned through a process of social interaction with others. Thus, pro-social behaviors must be learned to replace deviant behavior. Effective approaches include: therapeutic communities, self-help groups, family therapy, contingency contracting, role playing and modeling, vocational and social skills training, training in interpersonal cognitive problem-solving skills, and other programs involving ongoing peer monitoring of participants' behavior.[17]

Successful programs have several things in common: authority structures that clearly specify rules and sanctions, anti-criminal modeling and reinforcement of pro-social behavior, pragmatic personal and social problem-solving assistance, program staff knowledgeable about the use of community resources, and relationships between staff and clients which are empathic and characterized by open communication and trust. Ex-offender-addict counselors who serve as credible role-models of successful rehabilitation also are often utilized.[18] The "Stay 'N Out" program (see Appendix A) provides an example of a successful program that employs these treatment principles.

Conversely, unsuccessful programs are frequently based on a medical (disease) model of criminology which suggests that criminal behavior is a sickness.[19] Similarly, intervention programs based on deterrence models (e.g., "Scared Straight") have shown very limited effects and have even been associated with increased offending.[20] Other types of programs that have been unsuccessful include those that rely solely on open communication, "friendship" models, inmate-directed therapy groups, and those that are non-directive.[21]

While inmate-directed therapy groups have not had a record of success, behavioral programs that are simply imposed—without involving inmates in their development—do not appear to work either. Such programs are often focused on anti-social rather than pro-social behaviors and as a result give undue attention and reinforcement to negative behavior. Other features of unsuccessful programs include the failure to either neutralize or utilize the inmate's peer group and failure to sustain continuity of care after release from prison.[22]

A number of factors have been identified that degrade treatment integrity and impede treatment success.[23] Many are common to intervention programs in any setting. The absence of sound theoretical basis for treatment is a typical obstacle to the development of successful programs. Often, the quality and intensity of treatment interventions are inadequate. Sometimes programs propose treatment interventions that are based on sound principles which are not followed when the program is implemented. Another common problem is lack of staff training and treatment experience, and/or their inadequate commitment to both the clients' and program success.

Other impediments to the establishment and maintenance of successful treatment programs are related to a lack of correctional system support and the negative influence of inmate subcultures. Fundamental differences between custodial and treatment perspectives often contribute to the failure of the correctional environment to support program staff and goals. The lack of support from the custodial forces of an institution is exacerbated within prisons by the negative influence of the anti-authoritarian and anti-therapeutic "prisoners' code." Under this code, suspicion colors most interactions between staff and inmates. The result may be a program that receives neither staff support nor inmate cooperation.

Time in community drug treatment is inversely related to post-treatment cocaine-heroin abuse and criminality.

Turning to a more quantitative dimension of treatment programming, the available research clearly suggests the longer heroin and cocaine abusers remain in treatment, the greater the reduction in post-treatment criminality. Those who remain in community-based residential, methadone, or outpatient programs for more than three months have lower levels of both post-treatment heroin and cocaine abuse and criminality than those who drop out before three months and significantly lower rates than their own pre-treatment levels. Subsequent months of treatment in these programs yield even greater reductions in post-treatment criminality, especially after 12 months of treatment and after each subsequent treatment cycle.

Treatment personnel generally agree that it is hard even to stabilize the cocaine-heroin abuser's lifestyle in three months, much less begin to transform long-standing patterns of deviance. After three months, clients can begin to be comfortable with the treatment regime and start to make progress in changing disruptive patterns in their lives. However, due to the chronic relapsing pattern characteristic of the drug addict, several "cycles of treatment" are frequently necessary for hardcore drug abusers to achieve substantial improvement in their behavior and lifestyle.

Clients who leave treatment early against program advice are significantly more likely to recidivate than those who complete the recommended program. Early leavers who later return to treatment ultimately have less heroin use and criminality than those who fail to return.[24]

Outcome studies have shown that the first 12 months in treatment are critical to long-term reductions in criminality after leaving treatment. For cocaine and heroin abusers who are incarcerated and who participate in

prison-based therapeutic community programs, the optimum period of treatment appears to be nine to twelve months followed by release into the community. Longer stays are associated with diminishing results. It is believed this occurs for two reasons: First, longer periods of program participation while in prison creates increased dependency on the program and less transference of the learned experiences to the community upon release. Secondly, some persons are transferred as rehabilitated back into the general prison population after completing more than a year of treatment, and the criminal subculture undermines some gains made during the treatment period. Thus, the timing of treatment and release for prison inmates with serious drug abuse problems needs to be coordinated to achieve the optimum outcome.[25]

Conclusion

Clearly, much has been learned about effective ways of reducing the drug involvement of heroin and cocaine abusing offenders. Given the chronic recurring nature of addiction, no program can realistically expect to eliminate severe heroin and cocaine abuse for all offenders. Yet even if a program succeeds only in reducing the frequency of use, substantial reductions in criminality may follow. The evidence is clear: cocaine-heroin abusers commit much less crime when they use once or twice a week or less often than when they use once a day or more often. If, for example, daily cocaine-heroin users were placed under court-directed intensive surveillance and frequent urine monitoring which curtailed their use of drugs by half or more, a very substantial drop in their criminality would be likely to occur, especially in crimes such as robbery and burglary.[26]

Policy recommendations

What steps should be taken by the criminal justice system to deal more effectively with the drug-involved offender? Based on the research findings discussed in the preceding section and the experience and opinions of the authors, this section presents a series of policy recommendations. While it may not be possible to institute all or even most of these recommendations in many jurisdictions, they are offered as goals or guidelines for the practitioner. We argue that the interventions proposed will improve the system by leading to the effective integration and coordination of offender supervision and drug treatment approaches.

Beginning with the crucial need to identify heroin and cocaine abusers at arrest, the recommendations focus in turn on jail-based interventions, in-prison programs, and community treatment options. Also included are system-wide recommendations pertaining to the organization and staffing of drug abuse treatment programs. All of the recommendations presented in this section call for the criminal justice system to supervise cocaine-heroin users frequently and systematically:

- Convicted cocaine-heroin abusers under community supervision should be intensively supervised and compelled to attend treatment for their maximum period of custody. Optimal supervision includes near daily validation of employment, time in residence, associations, and absence of drug use.

- Convicted cocaine-heroin abusers sentenced to prison should be required to participate in drug treatment for nine months to one year prior to release *and* to continue in community treatment as a condition of parole. Their urine and behavior should be carefully monitored while under field supervision to insure attendance and prevent relapses.[27]

- Steps should be taken to ensure that drug-involved offenders in city and county detention facilities are placed in treatment after release. During their confinement, methadone maintenance should be continued for addicts previously assigned to this program or initiated for other heroin users. Naltrexone combined with urine surveillance should be used for those heroin users on work release who opt for drug-free treatment.

The identification of drug-involved offenders

In areas with a large number of heroin and cocaine users, urinalysis should be used to identify these users at arrest.

Most cocaine-heroin abusers who have contact with the criminal justice system are arrested about once per year. Results of the pretrial drug-testing

program operating in Washington, D.C. suggest that recent users of cocaine or heroin can be identified accurately at arrest through urinalysis. By collecting urine samples from all arrestees, and analyzing the specimens for five types of drugs including opiates, the D.C. Pretrial Services Agency has been able to identify and increase supervision of drug users released pending trial. These procedures appear to have reduced the rates of rearrest and failure-to-appear. Moreover, by systematically retaining the results of the urine tests, the information has been made available to help determine appropriate criminal sanctions for those arrestees ultimately convicted.[28]

The costs of a urine testing program may be amply justified in any jurisdiction with a significant drug problem. As in D.C., the data collected should be systematically maintained and used for determining conditions of pre-trial release and sanctions for those convicted. In particular, the opportunity should be seized to present appropriate treatment options.

Jail-based interventions

Treatment orientation and referral to drug treatment programs should be instituted in metropolitan courts and jails.

A central intake staff and/or representatives of drug treatment programs should be present at court and in jails. All offenders who test drug positive at arrest should be required to attend orientation and preliminary intake procedures while in detention. These preliminary treatment steps may help ensure that those who are released from custody are placed in appropriate treatment after returning to the community.[29]

Full treatment interventions, however, should not be initiated for cocaine-heroin offenders who will be free of custody in less than three months. It is neither cost effective nor therapeutically wise to implement full treatment programming when there is little expectation that treatment can be completed.

Methadone programs should be permitted to maintain clients in jails to facilitate resumption of treatment at the end of detention.

Methadone treatment has proven effective in reducing daily heroin use and substantially reducing criminality among heroin abusers. Enrolled methadone clients who are arrested can be maintained on methadone while detained. In this way, return to methadone treatment upon release after short-term jail custody would be facilitated. Those who are convicted and sentenced to incarceration should be given the option (when medically recommended) to remain on methadone or to detoxify from methadone and enter an in-prison therapeutic community. Consideration should also be given to initiating methadone treatment in jails for chronic heroin addicts. Heroin addicts serving short sentences who are introduced to methadone treatment while incarcerated are more likely to enter and remain in methadone maintenance treatment in the community when they are released from custody.

Daily naltrexone consumption should be used for some convicted heroin abusers in combination with drug-free treatment and intensive supervision.

For *heroin-abusing* offenders who receive jail or probation sentences *and* who opt for drug-free treatment, use of naltrexone (Trexan®), combined with urine surveillance, could be instituted. Its use with jail inmates on work release or school furlough appears particularly appropriate. Naltrexone is an easily administered narcotic antagonist drug which taken daily produces almost immediate withdrawal symptoms in addicts when they use an opiate, but is harmless to nonaddicts. It is most effective with heroin-addicted offenders who have a high level of community integration. It has no effect on cocaine, however; therefore, urine monitoring *must* be sustained.[30]

In-prison treatment

Therapeutic communities and other intensive milieu drug treatments should be made available to cocaine-heroin abusing state prisoners about one year prior to parole eligibility.

A successful therapeutic community, the "Stay 'N Out" program (see Appendix A), was developed at two correctional facilities in New York State—one for men and one for women. This model therapeutic community in prison holds the greatest promise for changing hard-core drug-abusing inmates and reducing recidivism.[31]

Despite their proven effectiveness, few therapeutic communities such as "Stay 'N Out" are in place for criminally involved drug abusers. One of the factors that limits the creation of additional programs of this type is the concern that such programs might engage in activities that threaten security and encourage inmate resistance to the correctional system. Nonetheless, correctional administrators learn quickly as they become exposed to the operation of well-run programs that such undesirable variance can be avoided. In fact, in institutions where most of these programs have been established, the wardens and correctional officers frequently are their most vocal champions. To encourage their development, however, staff and administration need education and training. Further, a number of fiscal and practical issues have to be addressed prior to implementation.

The implementation of prison-based treatment programs requires isolation from the general prison population.

The inimical influence of the criminal inmate subculture ("prisoners' code") will inevitably undermine any attempts to establish viable programming if the program is not isolated from this anti-therapeutic force. Separate living quarters, recreation, food services, etc. should be maintained within the institution for this separation to be ideally effective. Total isolation is, however, neither necessary nor desirable; rather, some contact with the general inmate population is useful for the purpose of allowing the inmate in treatment to see where he has come from and how much he has

changed. In addition, the contact experience provides the opportunity for the program resident to test both his new prosocial values against the inmate subculture and his resistance to negative influences. This kind of isolation is most possible in medium security institutions with dormitory-type housing space where one dormitory or two are physically segregated or separable from the main institution.

Prisoners in therapeutic communities who make good treatment progress should be paroled to residential drug-free programs that sustain the therapeutic community model prior to completion of their sentence. They should be required to stay in treatment as a condition of parole until their date of maximum custody or until the program deems them recovered.

It is essential for the successful treatment of cocaine-heroin abuser offenders to maintain continuity-of-care from the outset of treatment to termination of custody. While there is benefit from prison treatment alone, these effects are augmented and sustained by continuing that specific treatment in the community.

Ideally, release to the community facility would be contingent on the progress made during in-prison treatment. Under this incentive system, specific behaviors would be rewarded with a specified number of restitution or release "points" that might be administered as a form of "good time" system. Alternatively, prisoners might earn more favorable conditions of confinement or higher status and associated program privileges. However it is administered, the basic notion is to reinforce the desirability of pro-social behaviors.

Community treatment programs

Drug-abusing misdemeanants should be considered for community-based sentencing alternatives.

In lieu of confining drug-involved offenders in jails and county penitentiaries, a range of intermediate sanctions should be considered for heroin and cocaine abusers convicted of misdemeanors. These might include house arrest with electronic monitoring, intermittent sentences (e.g., weekend or evening incarceration), TASC programs, or residence in a facility such as a "halfway in-halfway out" center (a "HiHo"). Again, in any of these alternatives offenders would ideally be able to achieve release status more quickly by providing drug-negative urine samples, routinely attending and participating positively in treatment sessions, paying back their victims, and providing evidence of prosocial activity.[32]

The community treatment resources available to support intermediate sanctioning policies range from self-help groups that meet once a week for a couple of hours to residential facilities that provide 24 hour supervision and programming. At a minimum, almost all communities have an Alcoholics Anonymous or Narcotics Anonymous group that provides an

context for recovering substance abusers to meet, discuss day-to-day steps for maintaining a drug free life, and participate in many different types of social activities not involving alcohol or drugs.[33] Some communities provide drug treatment counseling through the Department of Mental Health. And in many cities, recovering substance-abusers operate group homes that use many of the same principles of Alcoholics Anonymous or therapeutic communities found in prison programs.

TASC programs run throughout the nation provide staff who are familiar with the particular resources available for drug-involved offenders in specific communities. And almost all states have an agency that periodically determines the availability of both private and public programs available for drug treatment. A list of these agencies is available from the National Association of State Drug and Alcohol Abuse Directors, in Washington, D.C.[34]

Even if no other treatment is provided, heroin-cocaine abusers who are on probation and parole should be required to have frequent urine tests.

Drug-abusing offenders on probation or parole who are in no special treatment programs, as a minimum should be routinely required to provide specimens for urinalysis over the entire length of their probation or parole. At the outset the frequency of urinalysis should be near daily, and decreased as positive progress warrants. The effective monitoring of urinalysis results will help to interrupt relapse to daily heroin or cocaine use, and, hence, high-rate criminality is likely to drop substantially.[35] When drug positive urines are detected, offenders should be immediately confronted, clearly warned after the first such incident, be required to enter treatment for diagnosis and assessment after the second positive urine, and be required to remain in treatment if relapse seems imminent or has occurred. Refusal to enter treatment upon an affirmative diagnosis should be considered a violation of release conditions.

Organization and staffing issues

The integrity of the treatment programs for convicted offenders must be maintained by developing structural safeguards of independence and autonomy from correctional management.

All too often well designed interventions operated by competent and motivated agency and institutional staffs do not succeed. Usually, the efforts are not trusted by the criminal justice clients, are overwhelmed by the difficulty of the clients' problems, are weakened by inadequate funding and institutional resistance, and are subject to high rates of staff burnout and turnover. For a treatment program to last long enough to make a substantial difference, it must maintain its own integrity, i.e., honesty and commitment to the treatment goals and program participants. The staff must also have sufficient independence and automony to deliver on their promises.

Treatment programs conducted by organizations independent of (but closely linked to) corrections agencies are more likely to maintain their integrity than programs operated by correctional staff within institutions or community corrections settings. This suggests that an outside agency working in cooperation with or under contract to the Department of Corrections may be the most appropriate treatment organization. Management responsibility for the rehabilitation program should be assigned to a team of committed treatment professionals, as well as ex-addict/ex-offender peer counselors. For this approach to work, the power and authority of the treatment team should be comparable to and complement the criminal justice authority. This management group should be associated with and monitored by respected professional self-help/therapeutic community organizations, for example, Therapeutic Communities of America.

Probation and parole officers should have their functions divided into Surveillance Officers and Community Treatment Team Leaders.

For many years, correctional observers have debated the wisdom of vesting probation and parole officers with the potentially conflicting responsibilities of surveillance and treatment. In the opinion of the authors, surveillance and treatment functions of field supervision officers should be separated to resolve the inherent conflicts and strengthen each function. Essential to the effectiveness of the treatment/counseling relationship is trust and confidentiality. Persons under field supervision are unlikely to freely admit criminal acts or drug use to someone in a position to return them to prison for such violations. Therefore, surveillance and rehabilitation responsibilities should be handled by staffs who work separately but cooperatively to avoid role confusion for both officer and offender. As the next recommendation suggests, both types of officers should be augmented by carefully selected ex-offender-addicts who would serve as Monitors for the Surveillance Officers and as Treatment Team staff for the Community Treatment Team Leader.

The Treatment Team staff should rotate between working in prison and the community to maintain continuity between the rehabilitation efforts in both environments. For in-prison programs, the objective of separating custodial and treatment functions is satisfied by the organization discussed in the preceding point.

Former addict-offenders who have shown clear evidence of prosocial change should have training and employment opportunities, for example, as Monitors and Treatment Team members.

Large numbers of offenders who have been chronic cocaine-heroin abusers are unable to gain and to keep legal employment. Their background is so limited and so stigmatized that legal employers are reluctant to employ them, and suspicious after they do. Thus, even after making good treatment progress, many offenders may still be unable to gain stable employment. First, systematic skill development and training programs should be provided. Second, providing employment to ex-addict-offenders within the treatment program itself is a valuable opportunity to deal with this unemployment issue as well as cope with shortages of field supervision personnel.

The employment of ex-addict-offenders in a variety of progressively more responsible paraprofessional and professional roles will help new monitoring and drug treatment systems function effectively. They also will serve as role models to offenders they supervise. The ex-addict offenders are the role models (as in "Stay 'N Out") whose presence demonstrates the realistic possibility of achieving successful rehabilitation. Graduation from a drug treatment program, evidence of successful integration into community life, and additional training are prerequisites for the employment of ex-addict-offenders as Monitors and Treatment Team members.

Conclusion

By substantially reducing their cocaine-heroin abuse, the criminality of drug-involved offenders may be reduced by 20 to 50 percent or more. To do so, however, the criminal justice system must develop an alliance with the drug treatment system geared to achieve the goals of effective rehabilitation, enhanced prosocial behavior, and reduced recidivism.

The difficulties inherent in bringing about this alliance should not be minimized. Some reallocation of resources clearly will be required, with all the tensions attendant on any significant shift in funding and operational priorities. If custodial and treatment functions are to be effectively separated, recruitment, training, and retraining programs will have to be developed for community corrections personnel. Institutional corrections environments must be prepared to accept independent treatment organizations. Procedures must be developed to identify and train those therapeutic community graduates best qualified to become competent treatment team members and monitors. The problem of intensive community resistance to accepting community treatment facilities (HiHo's) that house felons and substance abusers must also be addressed. Within prisons, space will have to be reallocated to create therapeutic communities to house clients during treatment. If institutions are converted for total therapeutic community utilization, abandoned mental hospitals may be utilized, with significant capital expenditures necessary for conversion. Beginning at the point of arrest, screening procedures will have to be developed to monitor drug use and to identify cocaine-heroin users who can most benefit from the proposed interventions.

Perhaps most important, cooperation will be needed among stable drug abuse agencies and drug treatment programs and criminal justice organizations (courts, probation, corrections, and parole) that traditionally have had competing political and fiscal interests and often lack a history of successful joint ventures. Careful documentation of pilot results will also be needed to evaluate whether the system is moving in desired or unanticipated directions. For this, evaluation researchers will have to be in place from the outset. Since many problems will arise that have the potential for compromising the interventions, the evaluation design must provide decision makers with timely information to assist them in formulating corrective actions. At the same time, ongoing dissemination of outcome information through professional and media channels will help foster and maintain the support necessary to accomplish the changes proposed.

Appendix A—"Stay 'N Out": A model for prison-based drug treatment

"Stay 'N Out" is a therapeutic community (TC), in part based upon the Phoenix House model, that has been operating in the New York State prison system for the last ten years. Over time the program has been modified to operate more effectively within the prison environment. The program has been fortunate to be operated by many of the founding staff who have provided the vision, commitment, and determination necessary for a successful prison program.

An early evaluation of the "Stay 'N Out" program indicated that it was successfully implemented, maintained a positive TC environment, and produced positive psychological and behavioral changes in participants. In 1984, the National Institute on Drug Abuse funded an evaluation of "Stay 'N Out", comparing it to two other prison-based programs in New York State and a control group of inmates on program waiting lists, but receiving no treatment. A milieu program and a standard counseling program were the comparison groups. Although participants were not randomly assigned to these treatment conditions, preliminary results of the comparison are provocative. The data indicate the "Stay 'N Out" participants who remained in the program for nine to twelve months were less likely to have problems while on parole than either those who left "Stay 'N Out" earlier or those in other prison-based programs. For example, "Stay 'N Out" participants who remained in the program more than nine months were more likely to have a positive parole discharge (80 percent positive) than those who remained in the program less than three months (50 percent positive). Positive parole discharge is defined as no reported violations of parole during the parole custody period. Long-term (9-12 months) participants of the other programs studied also had fewer cases of positive parole discharge; the milieu program reported a 56 percent positive discharge rate and the counseling program a 47 percent positive rate.

Preliminary analysis indicates that long-term "Stay 'N Out" participants may also have a more encouraging pattern of re-arrest than those in the other programs. Continuing follow-up shows that only 27 percent of the TC participants were re-arrested compared to 35 percent of the milieu participants, 50 percent of the counseling participants, and 42 percent of the waiting list persons. In addition, TC participants averaged 18 months to re-arrest compared to 11 months for the milieu and nine months for the counseling group. These data should be interpreted with caution, however, as variation in the actual number of days at risk may vary greatly among samples.

Program overview

"Stay 'N Out" programs were begun as a joint effort among New York State Division of Substance Abuse Services (DSAS), New York Therapeutic Communities (NYTC), New York Department of Correctional Services (DOCS), and the New York State Division of Parole. Currently, NYTC operates the programs, DOCS supplies funding, and Parole provides increased opportunities for program residents. The DSAS Bureau of Research and Evaluation continues to evaluate the program.

The current program consists of two treatment units for male inmates in one facility with 35 beds per unit (a total capacity of 70 beds), and one treatment unit with 40 beds for women inmates in another facility. Each unit is staffed by a total of seven persons, including both professionals and para-professionals. Inmates selected for the programs are recruited at State correctional facilities. The criteria for selection are: history of drug abuse, at least 18 years of age, evidence of positive institutional participation, and no history of sex crimes or mental illness. "Stay 'N Out" clients are housed in units segregated from the general prison population. They eat in a common dining room, however, and attend morning activities with other prisoners. The optimum length of treatment is from nine to twelve months. Most program staff are ex-addict-offenders who are graduates of community TCs; they act as "role models" exemplifying successful rehabilitation. The course of treatment is a developmental growth process with the inmate becoming an increasingly responsible member of the program.

During the early phase of treatment, the clinical thrust involves assessment of client needs and problem areas. Orientation to the prison TC procedures occurs through individual counseling, encounter sessions, and seminars. Clients are given low-level jobs and granted little status. During the later phases of treatment, residents are provided opportunities to earn higher-level positions and increased status through sincere involvement in the program and hard work. Encounter groups and counseling sessions are more in-depth and focus on the areas of self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. Seminars take on a more intellectual nature. Debate is encouraged to enhance self-expression and to increase self-confidence.

Upon release, participants are encouraged to seek further substance abuse treatment at cooperating community TCs. Extensive involvement with a network of community TCs is central to the program's operation. Staff and senior residents of community TCs visit "Stay 'N Out" on a regular basis to recruit resident inmates for their programs. These visitors provide inspiration since they are ex-addicts and ex-felon role models who are leading economically and socially productive lives.

"Stay 'N Out" Components

Program Elements

- Isolated Unit
- Utilization of Ex-Offender/Ex-Addict Staff
- Establishment of Psychological and Physical Safety
- Hierarchical Therapeutic Community
- Confrontation and Support Groups
- Individual Counseling
- Community and Relationship Training
- Program Rules with Opportunities to Learn from Misbehavior
- Immediate Discharge for Drug Possession, Violence and Sexual Misbehavior
- Developing Pro-Social Values: Honesty, Responsibility, and Accountability
- Continuity-of-Care: Networking with Community TCs

Administrative Components

- DOC Contract Arrangement with Private Agency
- Administrative Offices Outside Prison
- Membership in Local and National Professional Organizations
- Maintain Political Relations with Alternative Funding Sources and Legislators

Institutional Relations

- Earned Respect of Prison Administrators and Guards
- Development of a Model Unit Impressive to Visitors
- Placement of Program Residents in Important Prison Jobs

Relations With Inmate Culture

- Earned Respect of General Population Inmates
- Opportunities to Test TC Values

Glossary

Contingency contracting: A behavioral modification technique in which desired behaviors are negotiated or contracted for and rewards or sanctions meted out as that contract's obligation is fulfilled.

Detoxification: Gradual removal of an illicit substance from a user's body through decreasing dosage of that substance with the support of therapeutically compatible substances.

Electronic monitoring: A supervision system using electronic devices, usually anklet/bracelets, which emit coded signals to a central computer monitoring system. This system allows continuous monitoring of persons under house arrest.

Full treatment intervention: The maximum use of combined treatment resources, for example, drug treatment programs, urinalysis, intensive counseling, etc.

Hi-Hos (Halfway In - Halfway Out Houses): Transitional residential facilities in which releasees are supervised by both prison staff and community services personnel.

House arrest: A system of incarceration in which an offender is confined to his or her own home instead of in a traditional correctional facility.

Intermediate sanction: A sanction more severe than traditional probation and less onerous than incarceration.

Interpersonal cognitive problem-solving: Therapeutic techniques which teach an array of skills and strategies for resolving problems, particularly those encountered in relations with others.

Intervention: A therapeutic regimen or action designed to stop or change an individual's course of drug use or criminal activity.

Methadone: A long lasting (24-36 hours) synthetic narcotic analgesic medication.

Methadone treatment: The use of methadone, administered orally in daily dosages, to either detoxify or maintain (through maintenance of same dosage level) a narcotic addict.

Milieu Program: Therapeutic programs in which participants live together in an isolated environment designed to promote behavioral change; see also therapeutic community.

Misdemeanor: A relatively minor violation of criminal law, generally penalized through fines or a short period of incarceration.

Modeling: An attempt to gradually alter behavior through observation of socially appropriate behavior.

Narcotic antagonist: (Naltrexone, Naloxone, Narcan) A substance designed to discourage the use of opiates through two actions: 1) when introduced into a user's system *after* ingestion of narcotics, withdrawal ensues; and 2) when introduced into a user's system *prior* to ingestion of narcotics, the pharmacologic effect of the narcotics is blocked.

Opiate: Any natural drug derivative of opium or synthetic opiates with similar pharmacological action (methadone, percodan, Dilaudid) capable of producing physiological addiction and withdrawal symptoms with repeated use.

Prisoners code: An unwritten code of ethics developed by the culture in a prison setting with its own norms, values, and sanctions. This code is in general hostile and suspicious of authority and discourages cooperation with officials of the correctional system or their representatives.

Prosocial: Socially acceptable.

Recidivism: An offender's return to patterns of criminal behavior or drug abuse which were evident prior to treatment or incarceration. This may include official re-entry into the criminal justice system, for example, re-arrest, or a return to drug use or criminal activity even if undetected officially.

Restitution: A system of pay back or reparation for an offense either to society in general or to specific victim. Restitution may be made a condition of release.

Restitution points: A behavioral accounting system in which a quantifiable sequence of steps using positive and negative reinforcement determine speed of release from incarceration.

TASC: (Treatment Alternatives to Street Crime): A national program which provides alternatives to incarceration and assistance after release to substance abuse offenders through referrals to drug treatment and special supervision programs.

Therapeutic community (in drug treatment): A specific type of Milieu Program; a residential, drug free treatment program utilizing community or peer counseling, role modeling, and increasing levels of responsibility to prepare for re-entry into the community. Programs require full-time participation and may last a few months to over a year.

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