Reorganizing Care for the Substance Using Offender—The Case for Collaboration

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THE INTERSECTION between drug abuse and crime has been well documented. Drug and alcohol abuse are associated with large numbers of criminal acts. The response to drug-related crime has incorporated both public health (drug abuse treatment) and public safety (criminalization of illicit drug possession and sales, zero tolerance laws, stiff penalties for drug-involved offenses, and close monitoring of illicit drug use by those released to continuing criminal justice supervision in the community). As a consequence of the major emphasis on criminalization of drug use over the past three decades, it is estimated that about three-fourths of the offenders in correctional institutions have substance use disorders (SUD). Since most offenders are released to return to their communities, the numbers of individuals with SUD who have past or current criminal justice involvement has also grown (BJS, 1998; Belenko and Peugh, 1999; Mumola, 1999). This growth, together with experience showing that the substance-abusing offender is likely to relapse without drug treatment, has kindled interest in improving access to drug treatment programming for incarcerated offenders, those returning to the community, and offenders under community supervision.

Research on drug abuse treatment indicates that structured behavioral and multi-modal treatment approaches can reduce drug use and recidivism and improve post-incarceration outcomes, especially when paired with post-incarceration treatment and support services (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Falkin, Wexler, and Lipton, 1992; Hiller, Knight, and Simpson, 1999; Hiller, Knight, Broome, and Simpson, 1996; Inciardi, Martin, Butzin, Hooper, and Harrison, 1997; Gendreau, 1996; Lipton, 1995; Pelissier & McCarthy, 1992; Peters & Steinberg, 2000; Sherman, Gottfredson, MacKenzie, Eck, Reuter, and Bushway, 1997). Less well understood is how public safety and public health systems should be organized to work together to provide critical continuity of care across systems for these individuals who have multiple problems that require access to multiple health, social service, and criminal justice systems to successfully re-integrate into the community. The dearth of research-based knowledge has not stopped many criminal justice and community treatment agencies from developing their own models of service integration to address the problems that offenders present to the community, either within the institution or at large. Though the assumptions as to the nature of the problem may differ, there appears to be basic agreement that the current response is inadequate, as we expect to release approximately 600,000 offenders back into the community each year for the foreseeable future (Travis, 2002), many of whom have significant untreated substance abuse problems.

The aim of this paper is two-fold. First we propose to build on the emerging research suggesting that drug dependence is a long-lasting disorder with many aspects of a chronic condition. Second, we propose to highlight a continuum of collaborative structures that policy-makers and practitioners may want to consider as they begin to develop strategies aimed at integrating both across (horizontally) and within (vertically) the multiple systems involved with managing the criminal justice-involved substance user.

Addiction as a Chronic Condition

The persistence of drug addiction has been observed for many years; however, the basic neuroscience needed to understand the nature of the disorder has only been carried out in the past decade. A substantial and growing body of research identifies drug dependence as a complex, multi-layered disorder that affects the brain and behavior in long-lasting ways. Research conducted in both animals and humans shows that drugs produce neurological changes that persist long after the individual has stopped drug use (NIDA, 1999). These changes may help to explain why an individual addicted to drugs is likely to relapse even after long periods of abstinence. Studies comparing chronic disorders such as diabetes, asthma, and hypertension find that these medical conditions reoccur at rates similar to drug addiction relapse (McLellan, Lewis, O'Brien and Kleber, 2000).

An implication of this emerging concept of the addictive disorder is that the effectiveness of drug abuse treatment should not be based on the

outcome of a single episode of care, but rather on whether the treatment continues to be provided as needed over the course of the disorder. Long-term treatment may be required before the individual can alter behavior and thinking patterns associated with drug use, and the social and behavioral consequences of drug use may take even longer to resolve. We must place more emphasis on developing treatment models that more closely match the drug disorder and that meet the needs of the individual patient.

A drug abuse treatment model designed to address the chronic nature of the drug dependence disorder would not be limited to primary intervention but would include ongoing monitoring and support to enhance treatment adherence over the long term (McLellan et al., 2000). Such a treatment approach also has important implications for criminal justice supervision. Greater effort should be given to developing sustainable linkages across systems to meet the complex social, behavioral, and physical health needs of offenders with SUDs, and to creating better models for integrating monitoring and service delivery components that are necessary to achieve long-term changes.

The Need for Collaboration

It has been estimated that nearly 70 percent of state prisoners and over half of federal prisoners have drug or alcohol problems (Mumola, 1999). Further, data from the National Household Survey on Drug Abuse (SAMHSA, 2002) suggestions that an estimated 21 percent of the 1.4 million adults who reported that they were on parole or some other form of community supervision were using illicit drugs. Many of these offenders have histories of physical or sexual trauma, or a current lifestyle that increases exposure to violence. Drug addiction also increases the offender's vulnerability to infectious diseases such as HIV/AIDS, tuberculosis, and hepatitis as well as physical and sexual trauma. In addition, many offenders have dysfunctional social relationships, deficits in education, social supports, and employment skills, physical or mental health problems, and criminal thinking habits that jeopardize successful community re-entry. Because the number and complexity of these problems can be overwhelming, many offenders with SUD will need substantial support to access necessary social and health services in the community over an extended period of time (Anno, 1991; Belenko and Peugh, 1999; McDonald, 1995; Wexler, Lipton & Johnson, 1988). These multiple-disordered individuals are often unprepared to take responsibility for managing their behavioral and health conditions for significant periods of time. Without some level of collaboration among agencies, the odds of relapse and recidivism, which often leads to repeated institutionalization, are high (Delany, Shields, and Fletcher, 2003).

Even with the expansion of treatment across the criminal justice system during the 1990s (Prendergast and Burdon, 2002), only a minority who need treatment receive care while under supervision. This is especially true of incarcerated populations. In a study by Belenko and Peugh (1999), only 13 percent of inmates with a need for treatment were receiving some form of help, which ranged from drug education programs, group or individual counseling, and self-help groups, to intensive therapeutic community programming. As a result, most prisoners will be released back to the community without having received treatment for their substance use (Travis, 2000), and without linkage to treatment in the community. These numbers threaten to overwhelm already stressed community correctional and treatment systems.

Since offenders with substance use disorders present such complex clinical and management issues both for correctional and drug abuse treatment staff, it is reasonable to propose that the best outcomes would result from a collaboration between public safety and public health professionals. The reality is that often there is little coordination between criminal justice and drug abuse treatment personnel. The correctional officer may recommend that the re-entering offender should get drug treatment, but have no direct communication with the treatment provider. This places the burden of reconciling competing system demands (e.g., criminal justice appointments, drug treatment, employment, medical/ psychiatric care, and other services) on the offender, who may be overwhelmed by the multiple requirements and choose to address the most pressing need (such as housing or employment) and neglect others. Eventually these other problems can re-emerge and result in re-entry failure.

How can drug abuse treatment and criminal justice agencies work together more effectively to improve the outcomes of offenders with substance use disorders? There are several strategies that might be implemented. The easiest is for the correctional officer and the drug abuse treatment provider to establish an informal network to communicate, share information in their respective areas of expertise, and support their common objectives. A somewhat higher level of coordination might add regularly scheduled as well as informal communication and coordination of treatment services with supervision activities and requirements. A further level of cooperation could employ formalized agreements, some sharing of resources and activities (e.g., cross-training of staff), and joint goal setting. Higher levels of integration are possible with the merger or oversight of missions, goals, and administrative functions (Konrad, 1996).

Developing a Strategy for Integrating Systems

Prendergast and Burdon (2002) imply that the last decade of efforts to introduce and sustain rehabilitative programs across the criminal justice system has led de facto to new systems of care that have more or less effectively worked to provide a better system of care for the SUD offender. To some extent this is correct, but, as they note, there are numerous factors that mitigate against stakeholder organizations developing collaborative linkages that help ensure continuity of care across programs and systems. To be sure, the growth in the population of offenders with SUD provides tremendous challenges for these fragmented systems as they seek to unify aspects of their systems to create a more coherent strategy. Charles McClintock's (1998) recent summary report on cross-agency collaboration provides a useful outline for thinking about how we can learn from current research and practice experience. Drawing from the work of Schor (1997), Konrad (1996) and Himmelman (1997), he conceptualizes a theory of collaboration in terms of structures, implementation requirements, underlying mechanisms, services linkages, and success requirements. For the purposes of our discussion, we will focus on the continuum of structures for building collaborative linkages, both vertically and horizontally, and key components of collaborative efforts (Konrad, 1996; Prendergast and Burdon, 2002). Finally, we will consider the need for evaluation in the collaborative process.

Collaborative Structures

Collaborative structures vary in both form and level of commitment and may be more or less useful in achieving the goal of a systems integration depending on the level of formality. Konrad (1996) identified five strategies along a continuum, including networking, coordinating, cooperating, consolidating, and integrating.

Networking

Networking stresses information sharing and support for common goals. This often occurs informally within and across systems but may be more problematic in organizations where one organization, usually criminal justice, appears to hold a superordinate position (Prendergast and

Burdon, 2002). Practitioners may feel constrained to protect information in order to maintain the integrity of the process. Creating the necessary trust may occur only after management in both organizations take steps to develop a common understanding of each other's goals and contributions to working with the SUD offender/patient and openly share expectations with staff below them. A formal framework for information sharing and opportunities for contact may also assist in this process.

Coordination

Coordination between organizations usually requires a little more effort in terms of synchronizing parts of each system to minimize barriers that hinder access to care. For example, probation and treatment supervisors may work together to coordinate the assignment of offenders to agency staff who maintain similar work schedules. This may make it easier for all stakeholders (offender, probation officer, and treatment practitioner) to meet regularly to discuss progress and minimize extra travel requirements on the offender who often has a fairly chaotic adjustment period during early recovery. This still requires little, if any, loss of autonomy, but will probably require a greater level of horizontal integration for mid-level managers.

Cooperation

Cooperative strategies assume most of the activities of networking and coordination but also require some sharing of resources and integration of activities. One such model is the co-location of drug treatment counselors in a community pre-release center. This would require formalized agreements between corrections and the community treatment program in terms of obtaining space and time to provide services, protection of records, as well as limits of confidentiality. It would also require the pre-release center to provide training to the counselors in the policies and procedures of the pre-release center and to identify how the counselor fits within the organization. An important consideration here is for each organization to give consideration to clearly delineating how counseling staff will participate in pre-release center activities such as treatment planning, staffing and supervisory meetings, and professional development.

Consolidation

McClintock (1998) notes that this level of collaboration requires substantial structural change. Often administrative and management structures may be merged while the functional units maintain line authority to provide services. DWI programs that were established during the 1980s incorporating probation and treatment under one roof are one example of consolidation. There was a program director with overall responsibility for management of the agency and separate managers for the probation and treatment units. There were common goals, a high degree of information sharing, and agency-wide job descriptions and staff training.

Integration

An integrated system of care is the complete merger of organizational components. Not only are administrative and management tasks shared, but staff also share a common process for achieving outreach, intake, and treatment and management. Such an approach may work best in rural settings where the resources are not great enough to provide for separation between probation and treatment, so a decision is made to hire clinicians and train them as probation officers. Though a possibility for role conflict exists, good training and supervision can help staff develop very strong integrated discharge plans that lay positive and negative sanctions for the SUD offender.

For the most part, community corrections and drug treatment will not achieve full integration, or even consolidation. However, careful attention to resources and setting mutual goals can help create opportunities for building new alliances. Achieving these new alliances requires not only a realignment of resources, but also thoughtful planning that can build trust over time so that the inevitable turf battles are minimized.

Key Components

A number of key components that have been cited above must be considered as collaborative enterprises are entered into. Probably one of the most important elements is the setting of goals for the collaborative effort. McClintock (1998) notes that attention must be paid to short-term, intermediate, and long-term goals. These should take into account the nature of addiction, other diagnoses, and behavioral issues including criminal lifestyles. Goals should be clearly specified in terms of stakeholder interest and how they will be measured over time. This leads to the next element that must be taken into consideration, the stakeholders. These include the SUD offender, the practitioner, program administrative staff, local and state policy makers, and community leaders. How they are to be included in the planning, delivery and evaluation of the collaborative effort (Konrad, 1996) is critical. Otherwise, the effort can easily be undermined.

Another important element is the need for formalization of procedures and sharing of resources—financial, personnel, and other. Does this collaborative enterprise require changes in program level policies and regulations or is legislation necessary to allow for sharing of staff and resources? Can "circuit breakers" (McClintock, 1998) be built in to allow stakeholders to maintain autonomy?

In terms of the service delivery system, which elements will be shared and which will remain separate? Will there be common information systems, use of instrumentation, staff? How will the offender's family be involved? The community? Will there be joint staffing and training? Where will the services be housed?

Finally, how will information be shared within and across systems? This becomes especially important as the offender moves from one level of care or supervision to another. Without a comprehensive plan for information management, it is likely that valuable time and effort will be lost as each transition becomes just one more disconnected episode. Further, the ability to monitor progress can be hampered when systems require duplication of effort of data collection, losing valuable historical data that can guide services.

Evaluation

Evaluation of collaborative enterprises is key to understanding both their operation and impact and in the end, it is necessary if it is to maintain the support of stakeholders (McClintock, 1998; Prendergast and Burdon, 2002). Both process and performance outcome evaluations are helpful. Process evaluations can help assess the structural strategies, inclusion of key elements, and impact of linkages across and within systems. Performance-based evaluations are necessary to demonstrate to stakeholders that progress is being made and thus, that the collaboration is worthy of continued financial support. However, before any evaluation is implemented, it is essential to clearly define what is meant by success and whether it is a short-term, intermediate, or long-term goal. Defining success only as abstinence, stable employment and housing may have little practical value for an offender who has been using illicit substances for 12 years and is completing his or her first formal treatment effort. If the offender achieves abstinence but dies of AIDS-related illnesses because his AIDS was not addressed by the service system, is this success? These difficulties highlight the need for stakeholders to work closely together to identify achievable, measurable outcomes that respond to the needs of the different stakeholder constituencies. It also highlights the need to develop a rich

dataset that includes both quantitative and qualitative information that can provide context to any measures of outcome.

Conclusion

Substance abuse among populations involved with the criminal justice system is a serious problem that requires both a public health and public safety response. Over the last decade, both systems have worked to expand sustainable programming to meet the multiple and complex needs of this population. However, the policies of criminalization over the past three decades have led to a crisis for the public health, public safety and allied health and social services systems. It is apparent that although treatment paired with continued supervision in the community can reduce drug use, and criminal behavior and improve social functioning, there remains a dearth of research to guide these systems in the development of collaborative efforts. Despite the trend towards increased systems collaboration, we will need to draw on the small but growing knowledge base in related human service delivery fields in order to develop strong conceptual and research models that can help define more clearly how these systems can more effectively work together to deliver care to these individuals with long-term needs.

References

Andrews, D.A., Zinger, I, Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). *Does treatment work? A clinically relevant and psychologically informed meta-analysis.* Criminology, 28, 369-404.

Anno, J. *Prison Health Care: Guidelines for the Management of an Adequate Delivery System.* Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, National Commission on Correctional Health Care.

Belenko, S., Peugh, J. (1999). *Behind bars: substance abuse and America's prison population, Technical report,* New York, NY: National Center on Addiction and Substance Abuse.

Bureau of Justice Statistics (1998). *Sourcebook of criminal justice statistics.* Washington, D.C.: U.S. Department of Justice.

Delany, P., Shields, J. & Fletcher, B. (2003). Special Issues in Treatment: Incarcerated Populations, in A.W. Graham, T.K. Schultz, M.F. Mayo-Smith, R.K. Ries, & B.B. Wilford, (eds.), Principles of Addiction Medicine, 3rd Edition. Chevy Chase, MD., American Society of Addiction Medicine, 553-565.

Falkin, G.P., Wexler, H.K. & Lipton, D.S. (1992). Drug treatment in state prisons, in *Extent and adequacy of insurance coverage for substance abuse services (Institute of Medicine Report: Treating drug problems Vol. II),* NIDA Services Research Series No. 3, Washington, D.C.: Supt of Docs., U.S. Govt. Print. Off.

Fletcher, B.W. (in press). The NIDA Criminal Justice Drug Abuse Treatment Studies (CJ-DATS), *Offender Substance Abuse.*

Gendreau, P. (1996) The principles of effective intervention with offenders. In A. Harland (Ed.), *Choosing Correctional Options that Work.* Newbury Park, CA: Sage Publications.

Hiller, M.L., Knight, K., Broome, K.M., & Simpson, D.D. (1996). Compulsory community-based substance abuse treatment and the mentally ill criminal offender. *The Prison Journal,* 76, 180-191.

Hiller, M. L., Knight, K., & Simpson, D.D. (1999), Prison-based substance abuse treatment, residential aftercare and recidivism. Addiction, 94, 833-842.

Himmelman, A.T. (1997). *Collaboration for a change: Definitions, models, roles and a guide to collaborative processes.* Paper presented at the New York State Department of Health Conference—Focusing the Message. Albany, New York.

Inciardi, J.A., Martin, S.S., Butzin, C.A. Hooper, R.M., & Harrison, L.D. (1997). An effective model of prison-based treatment for drug-involved offenders. *Journal of Drug Issues,* 27(2), 261-278.

Konrad, E. (1996). A multidimensional framework for conceptualizing human services integrated initiatives. In J. M. Marquart & E. L. Konrad (Eds.), Evaluating initiatives to integrate human services. San Francisco: Jossey-Bass.

Lipton, D.S. (1995). *The effectiveness of treatment for drug abusers under criminal justice supervision.* Research Report. Washington D.C.: U.S. Department of Justice, National Institute of Justice.

McClintock, C. (1998). *Healthy Communities: Concepts and Collaboration Tools, Summary Report, Cross-Agency Collaboration: Research Findings and Practitioner Experience,* New York State College of Human Ecology, Policy Perspectives.

McDonald, D.C. (1995). *Managing Prison Health Care and Costs,* Research Report: Washington D.C.: U.S. Department of Justice, National Institute of Justice.

McLellan AT, Lewis DC, O'Brien CP, Kleber HD (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA.* 2000; 284:1689-1695.

Mumola, C.J. (1999). *Substance Abuse and Treatment, State and Federal Prisoners in 1997. Bureau of Justice Statistics Special Report.* Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

NIDA (1999). *Principles of Drug Addiction Treatment: A Research-Based Guide*, Washington, DC: U.S. Government Printing Office.

Pelissier, B., & McCarthy, D. Evaluation of the Federal Bureau of Prisons Drug Treatment Programs. In: Leukefeld, C.G., & Tims, F.M., eds. *Drug Abuse Treatment in Prisons and Jails*. NIDA Research Monograph 118. Washington, DC: Supt. of Docs., U.S. Govt. Print Off., 1992. pp. 261-278.

Peters, R.H. & Steinberg, M.L. (2000). Substance abuse treatment services in U.S. Prisons. In D. Shewan &J. Deavies (Eds.), *Drugs and Prisons*. 89-116. London, U.K.: Harwood Academic Publishers.

Prendergast, M.L. and Burdon, W.M. (2002). Integrated systems of care for substance-abusing offenders, in Leukefeld, C.G., Tims, F. and Farabee, D. (eds.). *Treatment of Drug Offenders: Policies and Issues (pp. 11-126)*, New York, NY: Springer Publishing Co.

Schorr, L.B. (1997). Common Purpose: Strengthening families and neighborhoods to rebuild America. New York: Doubleday.

Sherman, L.W., Gottfredson, D. MacKenzie, D., Eck, J, Reuter, P. & Bushway, S. (1997). *Preventing Crime: What Works, What Doesn't, What's promising: Report to Congress*. Washington D.C.: Office of Justice Programs.

Substance Abuse and Mental Health Services Administration Office of Applied Studies (2002). *Results from the 2001 National Household Survey on Drug Abuse: Volume I. Summary of National Findings*. Rockville, MD. Office of Applied Studies.

Travis, J. (2000). *But they all come back: Rethinking prisoner reentry*. U.S. Department of Justice: Office of Justice Programs, National Institute of Justice.

Wexler, H.K., Lipton, D.S., and Johnson, B.D. (1988). *A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody*. Washington, D.C.: U.S. Department of State.