



URBAN INSTITUTE
Justice Policy Center
2100 M Street NW
Washington, DC 20037
<http://justice.urban.org>

Returning Home Illinois Policy Brief

Treatment Matching

**By Laura Winterfield and
Jennifer Castro**

Prepared for the Illinois Criminal Justice
Information Authority
August 2005

Returning Home: Understanding the Challenges of Prisoner Reentry is a longitudinal study of prisoner reentry in Maryland, Illinois, Ohio, and Texas. The study explores prisoner reentry across five domains: (1) the individual experience, as documented through interviews with prisoners before and after release from prison; (2) the family experience, as documented through interviews with family members of returning prisoners; (3) the peer group experience, as documented through prisoner interviews both before and after their release; (4) the community experience, as documented through interviews with key community stakeholders and focus groups with residents; and (5) the broader policy environment at the state level.

In Illinois, the John D. and Catherine T. MacArthur Foundation, the Rockefeller Foundation, the Woods Fund of Chicago, the Annie E. Casey Foundation, and the Illinois Criminal Justice Information Authority supported *Returning Home*. The Metro Chicago Information Center (MCIC) conducted the original data collection under the expert direction of Dr. Alisú Schoua-Glusberg.

This report was supported by Grant 02-DB-BX-0017 awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, through the Illinois Criminal Justice Information Authority. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice, or the Illinois Criminal Justice Information Authority.

As has been well documented, large and growing numbers of persons entering prison have a substance abuse problem. According to the Bureau of Justice Statistics, in 1997, 83 percent of state prisoners reported ever using drugs, up from 79 percent in 1991 (Mumola 1999). Additionally, in 1997, 57 percent had used drugs in the month before their current offense, up from 50 percent in 1991. These findings are mirrored in survey results from the National Center on Addiction and Substance Abuse, where over three-quarters of federal, state, and local jail inmates reported one or more of the following: use of an illegal drug on a regular basis; at least one drug-related conviction or alcohol-related driving violation; being under the influence of drugs or alcohol when they committed their most recent offense; or commission of their offense to get money for drugs (Belenko and Peugh 1999, 2).

Addressing substance use and addiction is viewed as an essential component of successful reentry, increasing the likelihood that former prisoners will find and keep jobs, secure housing, and forge positive intimate and familial relationships after their release. In addition, research has shown that in-prison drug treatment, when linked with postrelease continuity of treatment, can reduce postrelease drug use and enhance positive outcomes (Gaes et al. 1999; Knight et al. 1999; Martin et al. 1995; Harrison 2000).

Nonetheless, over the last decade, programming of all kinds—both within and outside of prison—has declined (Lynch and Sabol 2001). With regard to drug treatment in particular, fewer than one in four (24 percent) prison inmates nationwide reported receiving any drug treatment since their time of admission (Belenko and Peugh 2005). Petersilia (2005), based on a somewhat different analysis of the same data, reported that well under half (40 percent) of those with a severe drug problem receive appropriate services.

This shortage of services for those in need is likely to get worse: Policymakers, mindful of mounting budget crises at both the state and county level, have been cutting prison and community programs further. At the federal level as well, the proposed FY2006 Federal Drug Control budget reduces or eliminates funding for many state-level programs. Amidst this context of fiscal conservatism, making appropriate use of scarce resources is essential.

Given the overwhelming need for substance abuse treatment in the context of reduced service availability, we pose an important but rarely asked question concerning treatment matching: Are limited drug treatment resources being targeted to those with the greatest needs? This research brief examines the degree to which prisoners with self-reported drug problems receive in-prison substance abuse treatment services or participate in other substance use and addiction programs, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), and then receive postrelease treatment (or AA/NA) as well.¹ If those who report a problem are those who actually receive treatment, then a scarce resource is being wisely applied. However, if treatment is being given to those who do not need it, then the underlying referral and admission processes may be in need of review and revision. Further, because treatment continuity from prison to the community has been found to be important as well, a secondary analytical question to be explored here concerns the extent to which those who receive in-prison treatment also receive postrelease treatment, irrespective of their drug problem status.

DATA USED IN THIS ANALYSIS

Data used in this article were gathered during the prerelease survey and the first postrelease survey of the *Returning Home Illinois* study (see Methodology sidebar on page 7 for more details on the full study design). Of the 400 male prisoners in the *Returning Home Illinois* prerelease sample, 251 respondents completed a postrelease interview within 3.5 months of release and provided valid information about

preprison substance use, in-prison treatment, and postprison treatment. When the respondents were compared to the 149 prisoners not included, only two differences emerged as statistically significant in a multivariate regression: the 251 respondents were somewhat more likely to be African American, and they had slightly fewer prior incarcerations. These 251 male prisoners comprise the sample used in this analysis.

CONCEPTUAL APPROACH AND DEFINITIONS

The primary research question for this analysis concerns treatment matching: Did those most in need of substance abuse treatment receive treatment? Secondly, we are interested in examining the issue of continuity of treatment (both with and without regard to initial need): Did those who received in-prison treatment receive postprison treatment as well?

To determine if those most in need received treatment, three key constructs were developed: (1) preprison drug problem; (2) in-prison treatment/services, and (3) postprison treatment/services. The definitions for these constructs are as follows:

(1) **Preprison drug problem:** This construct was defined by combining two dimensions, mirroring the approach suggested by Belenko and Peugh (2005): self-reported drug use (type and frequency) and problems stemming from drug use during the six months leading up to incarceration. The operational definition of a pre-prison drug problem, then, was frequent use (a few times a week or more) of heroin, cocaine, or similar drugs; frequent drunkenness; or a report of any problems symptomatic of drug or alcohol abuse (e.g., used drugs or alcohol more or in greater amounts than intended, needed more drugs or alcohol to achieve same effect). Respondents who reported neither frequent drug use nor problems resulting from use were defined as having no pre-prison drug problem.

(2) **In-prison substance abuse services:** This construct was defined as self-reported receipt

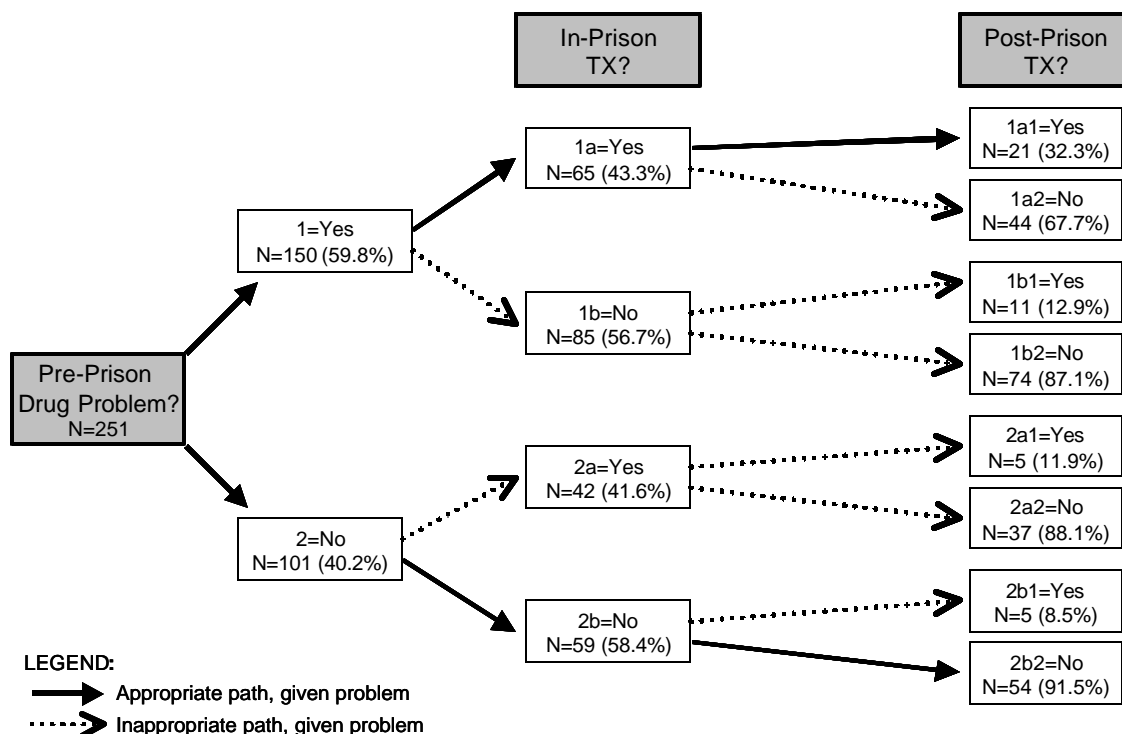
of substance abuse services in prison, including formal programs such as Residential Substance Abuse Treatment (RSAT) and any other outpatient substance abuse program, as well as self-help programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA). We include AA/NA as a form of substance use programming in accordance with previous Bureau of Justice Statistics researchers (see, e.g., Mumola 1999), but call attention to the distinction between AA/NA services and those provided by more formalized treatment programs. Notably, only 16 percent of those who reported receiving in-prison treatment/services had received only AA/NA; the remaining 84 percent received some other form of substance use treatment programming.

(3) Postprison substance abuse services: This construct was defined as self-reported receipt of substance abuse treatment services after release from prison, including outpatient substance abuse treatment or self-help programs (either AA or NA).² We note that most of the services being provided postrelease were

AA or NA: 67 percent of those reporting postprison drug treatment services were in AA or NA only. It is also important to note that AA/NA services in the community may be operating more formally than those in prison and frequently serve as the main type of service available.

Developing these constructs enabled us to create a flowchart of the relationship between having a pre-prison drug problem and receiving treatment at the two points in time (in prison and post prison). As shown in figure 1, “appropriate” treatment matching with continuity of treatment is presented in both the uppermost and bottommost paths: The first group is those reporting a drug problem (box 1) who received both in-prison treatment and postrelease treatment (boxes 1a and 1a1). The second group is those who reported no such problem (box 2) and received neither in-prison nor postprison treatment (boxes 2b and 2b2). The other boxes represent various combinations of either mismatches between need and services or discontinuity between in-prison and

Figure 1. Treatment Matching In Illinois



postprison treatment. Results are presented in figure 1.

FINDINGS

In this sample of prisoners returning to Chicago, Illinois, we found little evidence of treatment/service matching. As can be seen in the figure 1 flowchart (specifically, by examining box 1a and 2a), approximately 42 to 43 percent of those who say they *did* and those who say they *did not* have a drug problem before prison reported receiving some kind of in-prison drug treatment or related service. This finding can be viewed as problematic on two counts. First, there was no differentiation of treatment delivery based on need: Virtually the same proportion of prisoners received treatment regardless of whether they reported having a drug problem.³ Second, the proportion of those who needed treatment that actually received it was less than half.

Second, when looking only at the issue of continuity of treatment without regard to drug problem, only 24 percent of those who received treatment in prison (boxes 1a and 2a) received postprison treatment as well (boxes 1a1 and 2a1). This picture is substantially better among those with a drug problem who received in-prison treatment, with 32 percent also receiving treatment after release. Nonetheless, concern arises as to treatment outcomes when we consider that continuity of treatment exists for only a third of those receiving treatment that were ‘in need.’⁴ Furthermore, it is worth noting that if we exclude prisoners who participated in AA or NA *only* after release, then an even more discouraging picture of continuity emerges: Only 7 percent of those who received in-prison treatment (and 9 percent of those with a pre-prison drug problem who received treatment) also received substance abuse treatment after release.

Overall, the flowchart shows that nearly half of those with a preprison drug problem failed to receive needed treatment either in prison or after release (box 1b2 divided by box 1), and only 14 percent received the continuous treatment suggested by research as being most

effective in preventing relapse and recidivism (box 1a1 divided by box 1). These findings identify serious problems in the delivery of substance abuse treatment services, both in terms of initial matching of need to service as well as continuity of service over time.

POLICY AND PRACTICE IMPLICATIONS

TREATMENT MATCHING

Several reasons may explain the observed lack of treatment matching and continuity of services. These include lack of routine administration of screening instruments, divergence between the stated mission of many correctional systems as compared to that required to enhance access to services, and the reasons that inmates self-select into various programs. Each of these possible factors is discussed in turn.

First, routine administration of good screening tools will produce information that can be used to match services. There are currently several instruments in the public domain that might be effectively implemented for this purpose, including the Texas Christian University Drug Screen II (TCUDS II), the CAGE questionnaire, and the CRAFFT (see Inciardi 1994, and Broner et al. 2001, for a more complete review). The TCUDS II is a standardized 15-item tool that takes five minutes to complete and that has been used in large correctional settings around the United States. The CAGE and the CRAFFT, on the other hand, consist of four and six questions, respectively, that are easy to remember and which can be modified to screen for either alcohol or drug abuse. The CAGE has been used internationally on both adult and adolescent (see CAGE-AA) populations, while the CRAFFT was designed primarily for adolescents.

Another instrument currently in the testing phase is the Inmate Pre-Release Assessment (IPASS), being developed by Farabee and Prendergast as part of the NIDA-funded Criminal Justice Drug Abuse Studies. The primary focus of the IPASS is on pre-release assessment to determine the need for specific

postrelease drug placement. The instrument is to be administered approximately 90 days prior to release, and takes into account risk factors, in-prison treatment performance, and prisoner interest in as well as a counselor's assessment of need for postrelease treatment. It is currently being tested in four states.

The second issue is that there may be a disconnect between the processes and practices underlying the 'confinement model' of corrections (Logan 1993, 20–35) and those that would encourage access to programs. For systems that implement a routine screening and assessment protocol, it is important that policymakers view the results as equally important as security classification when making program assignments. In some systems, this may run counter to institutional policies usually given priority when making assignments, such as security risk and expected length of stay.

However, it may be possible to organize service availability for those with the greatest need by repositioning programmatic resources. For example, if a department finds that most of the high-need prisoners are also high-risk, they may choose to shift their drug treatment programming from lower-security to higher-security institutions. Or, regardless of location, if a department finds that the need for treatment far exceeds capacity, treatment programs may need to "prioritize" access by wait-listing prisoners according to drug abuse severity. Also of consideration to many systems is expected length of stay: How long must a prisoner be expected to remain in prison to receive an "adequate dosage" of treatment? Although the length of treatment needed will vary by the individual, research has shown that treatment of a minimal 90 days can be effective (NIDA 1999; Anglin and Hser 1990).

A third policy issue that should be examined with regard to treatment matching concerns institutional incentives for program participation, especially with regard to release eligibility. In many systems, prisoners receive credit for program participation, regardless of their need or the specific program content. Implementation of treatment matching would mean that prisoners' admission into drug programs would

be contingent on some assessment of need. For prisoners who are interested in receiving programming but are not accepted because of lack of demonstrated need, it will be important to put policies in place that offer them the possibility to accrue the same type of credits for an alternative program as those received by completing drug treatment or service.

Understanding many of these issues, in January 2004 the Illinois Department of Corrections (IDOC) implemented the Sheridan National Model Drug Prison and Reentry Program at the Sheridan Correctional Center.⁵ Since that time, Sheridan has become the largest fully dedicated drug treatment prison in the United States (Olson, Juergens, and Karr 2004).

With the opening of the Sheridan facility, IDOC instituted use of the TCUDS II to screen at reception every Illinois prisoner for a substance abuse problem. Those prisoners who meet eligibility criteria for the Sheridan program are then transferred to the facility, where they receive a full assessment and identification of treatment needs. During the program, inmates receive intensive substance abuse treatment in a therapeutic community, as well as educational and vocational programming, other forms of specialized programming (e.g., anger management, family reunification), and, prior to their release, assistance in developing an aftercare plan for meeting treatment and other service needs, such as education, housing, and employment. Upon their release, Sheridan participants receive referrals to various services in the community, including clinically-appropriate treatment and educational/vocational programs, job placement assistance, and linkage to a community mentor. It stands to reason that the analysis presented in this paper would have resulted in different findings had the *Returning Home Illinois* study been conducted after the opening of Sheridan. An evaluation of the effectiveness of the Sheridan approach is currently underway by the Illinois Criminal Justice Information Authority (ICJIA) and should provide information on the extent to which the model has resulted in more efficient treatment allocation decisions.

CONTINUITY OF SERVICES

Although the benefit of drug treatment service continuity is well-established in the research literature, it was not shown to be a common practice. Regarding strategies for enhancing continuity of services, SAMHSA has developed several *Treatment Improvement Protocol* (TIP) practice briefs on how to improve comprehensive case management (Siegal 1998) and offender treatment continuity (Field 1998). Interestingly, even though the focus of the documents is somewhat different (the case management TIP is primarily concerned with improvements in individual case management approaches, and the offender treatment continuity TIP focuses on cross-system strategies) both documents cite the importance of linking and managing service delivery across systems and agencies.

The case management strategies TIP offers three different organizational models that can be considered when thinking about increasing continuity of services. These range from an informal single-agency model (one manager reporting to a single agency) to a formal 'consortium' (multiple providers linked by a formal contractual arrangement). The offender treatment continuity TIP also describes various types of models, called program strategies, to enhance treatment continuity. The first is 'institution outreach,' in which a member of the institution's staff initiates linkages with agencies and services beyond the institution. The second is 'community reach-in,' in which the individual community agencies take responsibility for initiating contact and postrelease treatment before prisoners are released. Finally, there is the 'third party' model, in which an independent agency takes responsibility and serves as a liaison between the pre- and postrelease treatment agencies.

Each of the approaches discussed in the offender treatment continuity TIP specifies the key organization responsible for developing and maintaining the cross-agency links. The appropriateness of one model over another will depend on specific organizational constraints.

For example, the institutional outreach model may work best in organizational situations where the same organization manages both in-prison services and postrelease supervision, while the community reach-in approach may be more appropriate in situations where postrelease supervision is managed by an organization separate from the corrections department. Regardless of the specific organizational focus of the agency that develops the service links, the degree of formalization of the partnerships will be contingent on the number of partners and the formality of their organizational arrangements (as detailed in the case management TIP).

CONCLUSION

Although the current picture of treatment matching and service continuity based on our analysis of self-reported data from Illinois prisoners is somewhat disheartening, we have described several mechanisms that can be put into place to improve the existing processes. Simple and effective screening instruments exist in the public domain and adopting those instruments can be done with relatively little training, yet can lead to improvements in the linkage of substance-abusing prisoners to appropriate drug treatment. These principles are exemplified by the IDOC's use of a simple screening instrument and use of the results to refer prisoners to the Sheridan National Model Drug Prison and Reentry Program. This type of programmatic enhancement should lead to improvements in the linkage of substance-abusing prisoners to appropriate drug treatment.

Furthermore, as state and federal government agencies increasingly make funding contingent on employing evidence-based practices, correctional systems should focus on implementation of best-practice treatment approaches. Ideally, those programs will be offered first and foremost to the prisoners that need them, and they will include elements that ensure continuity of services beyond release. The current context of fiscal constraints may

provide the impetus needed to encourage more systems to embrace these practices.

Methodology

The Illinois Returning Home study entailed four separate data collection efforts with 400 male prisoners returning to the City of Chicago. Prisoners were recruited over a five-month period through the use of a preexisting reentry program known as PreStart. The Illinois Department of Correction (IDOC) requires the vast majority of prisoners to complete this two-week prerelease program, which is convened in groups of 10 to 30 prisoners in a classroom setting. This strategy resulted in a participation rate of 75 percent and the resulting sample was representative of all releases for the year based on factors such as major offense, admission type, release reason (MSR/parole, discharge, etc.), security level, time served, as well as demographic characteristics, such as race and age.

This analysis is based on data collected in one prerelease survey and three waves of postrelease interviews. The first survey was administered one to three months prior to release (N = 400). Postrelease data were collected from three subsequent waves of interviews: wave 1 data were collected at two to three months after release (N = 296); wave 2 data were collected between six and nine months after release (N = 266); and wave 3 data were collected between one and two years after release (N = 198).

END NOTES

¹ The distinction between substance abuse treatment and other services, such as AA/NA, is noteworthy because in-prison AA/NA programs may be run by prisoners themselves and may be substantively different than those operating more formally. For the purposes of this paper, we follow the practice of Bureau of Justice Statistics analysts (see, e.g., Mumola, 1999) and include all types of substance abuse programs under the guise of “treatment services.”

² The *Returning Home* questionnaire for the first post-release interview did not ask about receipt of in-patient residential treatment.

³ There is, of course, a possibility that some respondents represent ‘false positives’ (those who say they do not have a drug problem but actually do) and were ‘correctly’ screened into treatment. Although this possibility could not be disentangled in the *Returning Home* data, a host of

previous research on the validity of self-reports suggests otherwise.

⁴ Very limited information on in-prison referrals for community treatment after release was available: Only the 99 respondents who participated in a prerelease program where substance abuse prevention was discussed were asked about treatment referrals. Of these respondents, there was no significant relationship between receiving a community referral for treatment and actually receiving post-prison treatment.

⁵ The data analyzed in this report (N = 251) come from prerelease interviews conducted October 2002 to March 2003, and post-release interviews conducted December 2002 to July 2003. All interviews preceded opening of the Sheridan Correctional Center; thus, none of the prisoners interviewed were screened, assessed, or treated by the Sheridan program.

REFERENCES

Anglin, M.D. and Y.I. Hser. 1990. Treatment of drug abuse. In M. Tonry and J.Q. Wilson (eds.), *Drugs and Crime*. Chicago, IL: University of Chicago Press.

Belenko, S. and J. Peugh. 1999. *Behind Bars: Substance Abuse and America's Prison Population: Technical Report*. National Center on Addiction and Substance Abuse at Columbia University. New York, NY: Columbia University Press.

Belenko, S. and J. Peugh. 2005. *Estimating drug treatment needs among state prison inmates*. *Drug and Alcohol Dependence*, 77(3):269-281.

Broner, N., Borum, R., Gawley, K., and L. Whitmire. 2001. A review of screening instruments for co-occurring mental illness and substance use in criminal justice programs. In Landsberg, G., Rock, M., and L. Berg (eds.), *Serving Mentally Ill Offenders and Their Victims: Challenges and Opportunities For Social Workers and Other Mental Health Professionals*. New York: Springer Publishing.

Farabee, D. and M. Prendergast. 2005. *Inmate Pre-Release Assessment (IPASS)*. CJDATS Brief Report. National Institute of Drug Abuse, National Institutes of Health, Department of Health and Human Services web publication.

Field, G. (Consensus Panel Chair). 1998. *Continuity of Offender Treatment for Substance Use Disorders From Institution of Community*. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. TIP # 30.

Gaes, G.G., Flanagan, T.J., Motiuk, L.L., and L. Stewart. 1999. Adult correctional treatment., In M.

Tonry and J. Petersilia (eds.), *Prisons*, p. 361-426. Chicago, IL: University of Chicago Press.

Harrison, L. 2000. "The challenge of reintegrating drug offenders in the community." Paper presented at the Reentry Roundtable, October 12-13, 2000. Washington, DC: The Urban Institute.

Inciardi, J.A. (Consensus Panel Chair). 1994. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. TIP #7.

Knight, K., Simpson, D.D., and M.L. Hiller. 1999. Three-year reincarceration outcomes for in-prison therapeutic community treatment in Texas. *Prison Journal*, 79:337-351.

Logan, C.H. 1993. Criminal justice performance measures for prisons. In Dilulio, J.J., Jr., Alpert, G.P., Moore, M.H., Cole, G.F., Petersilia, J., Logan, C.H., and J.Q. Wilson, *Performance Measures for the Criminal Justice System*. NCJ #143505. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Lynch, J.P., and W.J. Sabol. 2001. *Prisoner Reentry in Perspective*. Crime Policy Report No. 3. Washington, DC: The Urban Institute.

Martin, S.S., Butzin, C.A., and J. Inciardi. 1995. "Assessment of a multistage therapeutic community for drug involved offenders." *Journal of Psychoactive Drugs*, 27(1):109-116.

Mears, D and G. Moore. 2003. *A Meeting of the Minds: Researchers and Practitioners Discuss Key Issues in Corrections-Based Drug Treatment*. Washington, DC: The Urban Institute.

Mumola, C. 1999. *Substance Abuse Treatment, State and Federal Prisoners, 1997*. Bureau of Justice Statistics Special Report NCJ 172871. Washington, DC: U.S. Department of Justice.

National Institute on Drug Abuse. 1999. *Principles of Drug Addiction Treatment: A Research-Based Guide*. NIH Publication No. 99-4180.

Olson, D.E., Juergens, R., and S.P. Karr. 2004. Impetus and implementation of the Sheridan Correctional Center Therapeutic Community. *Program Evaluation Summary*, Vol. 3, No. 1. Chicago, IL: Illinois Criminal Justice Information Authority.

Petersilia, J. 2005. Chapter 2 in Travis, J. and C. Visher (eds.), *Prisoner Reentry and Public Safety in America*. Washington, DC: The Urban Institute.

Siegal, H. (Consensus Panel Chair). 1998. *Comprehensive Case Management for Substance Abuse Treatment*. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. TIP # 27.