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► **Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: crime outcomes.**

Sacks S., Chaple M., Sacks J.Y. et al.
Journal of Substance Abuse Treatment: 2012, 42, p. 247–259.

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From the USA, the first randomised trial of a post-prison therapeutic community designed for psychologically disturbed problem substance using offenders found it halved the numbers reimprisoned and did even better when preceded by similar in-prison treatment, confirmation that what happens when people leave prison can be critical.

Summary Therapeutic communities are residential facilities with a distinctive therapeutic ethos and programme founded on joint living and peer influence. Core principles and methods include: a focus on the 'whole person'; a highly structured daily regimen; fostering personal responsibility and self-help in managing difficulties; using peers as role models and guides, with the peer community acting as the healing agent; regarding change as a gradual, developmental process and moving clients through progressive treatment stages; stressing work and self-reliance through the development of vocational and independent living skills; and promoting prosocial values within healthy social networks to sustain recovery.

Development of therapeutic communities for dual diagnosis prisoners

Implemented in the community such facilities have reduced drug use and crime while increasing employment rates. Implemented in and adapted to the prison setting, they have led to significantly greater reductions in recidivism to drug use and crime than usual procedures, especially when followed on release by continuing care in a therapeutic community.

Therapeutic communities [have also been adapted](#) to the needs of problem substance users who suffer from serious psychiatric symptoms. Programmes are more flexible and less intense, activities are sustained for shorter periods, confrontation is reduced, more guidance and instruction is offered, sanctions are fewer, achievements are more explicitly affirmed, and there is greater sensitivity to individual differences.

These adapted communities have been implemented in prisons for offenders with both substance use and mental health problems. Further modifications have included a cognitive-behavioural curriculum on criminal thinking and behaviour and classes on the relationships between substance use, mental illness, and criminality. These components together with the core elements are expected to curb criminal behaviour more effectively than usual prison regimens.

Colorado communities evaluated

Such facilities have been introduced in the US state of Colorado, where prisoners assessed as needing prison treatment programmes are required to attend them. The most psychiatrically disturbed are sent to a special facility, but the remaining population with substance use and mental health problems at entry could be required to undergo suitable treatment in prison, for which one option is a modified community of the type described above.

A [study](#) set in the same Colorado prisons as the featured study found that these communities did reduce post-release criminal recidivism compared to usual prison mental health and substance use services. Notably, just 9% of offenders randomly allocated to them were re-imprisoned compared to 33% after usual procedures. The figure was even lower among former community residents who on release entered the compatible residential parole programme. Former residents who did not enter the parole programmes evidenced no statistically significant crime reductions compared to usual procedures, though their reimprisonment rate remained less than half that of comparison offenders.

Featured study tests the parole phase

The post-prison phase was the focus of the featured study. In the previous study continuing care of offenders paroled from prison seemed to reduce crime. However, the offenders had not been randomly allocated to the parole programme, so this apparent effect might have been due to the type of offenders who opted for or were offered a place. Like the original study, the featured study recruited prisoners with both substance use and mental health problems, but instead of randomly allocating them to different prison regimens, it randomly allocated paroled prisoners to the modified community's continuing care programme or to usual facilities.

The specialist community programme was similar to the in-prison regimen – an intensive programme reliant on peer influence and guidance and based on therapeutic community principles adapted for offenders with both substance use and mental health problems. The usual facilities against which this was benchmarked were also residential, but the programme was less intense and consisted mainly of linking parolees to services in the community rather than providing them directly.

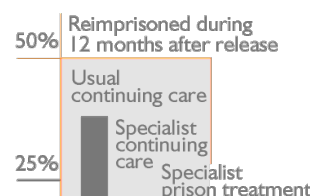
To join the study prisoners had to have been treated for their substance use and mental health problems at one of nine Colorado prisons and accepted for residential aftercare on leaving. Of 512 inmates offered the opportunity to participate in the study, 92 refused and 221 were refused a place in a community-based drug treatment facility. After other losses, 127 inmates were randomly assigned to the two parole care regimens. Just over half had at some time been homeless, nearly 80% had been treated for mental health problems, and when recruited to the study on average they were experiencing severe psychological distress. Over 8 in 10 had used cocaine, two thirds amphetamines, and half opiates. All had committed a drug-related offence and most too property and violent offences.

Main issue for the study was the impact of the aftercare regimen, but it also checked whether this worked better if prisoners had already been through the corresponding in-prison programme. Also of interest was whether regardless of the aftercare regimen this prison programme had (as in the previous study) been more effective than usual prison support.

Main findings

Over the 12 months after their release from prison the study drew on official records to determine how many of the offenders had been reimprisoned for new offences. At 19%, the proportion reimprisoned after being allocated to specialist continuing care was [half](#) that reimprisoned after usual continuing care, a statistically significant difference ► [chart](#).

Nearly 9 in 10 of the offenders could also be interviewed 12 months after their release, when 39% admitted re-offending after being allocated to specialist continuing care. However, at 62% the corresponding proportion after usual procedures was significantly higher, mainly due to alcohol- and drug-related offences.



In contrast, continuing care allocation made no significant difference to the proportions who admitted theft, possessing weapons, or violent offences.



Though not statistically significant, the advantage conferred by specialist continuing care was greatest when the offender had previously received the same kind of treatment in prison. Given this combination, just 13% were reimprisoned. It was also the case that prisoners who had undergone the specialist prison treatment were less than half as likely (19% v. 41%) to be reimprisoned as those subject to usual prison treatment, regardless of the type of continuing care. However, in the absence of random allocation, both these results could have been due to the type of prisoners who were offered specialist prison treatment.

Was it intensity, length or content which made the difference?

Both continuing care options were intended to last about six months, but in practice offenders stayed significantly longer (on average over 10 months) at the specialist service, which adapted duration to the resident's needs. Longer time in continuing care was associated with a reduced chance of being reimprisoned, raising the issue of whether the specialist option's duration rather than its programme accounted for its benefits. On the assumption that more time would have proportionately improved outcomes from usual aftercare, the specialist option's advantage would have been much reduced.

One way duration might have helped is because the residential environment limited opportunities for crime. If this was the case, it would be expected that offenders in what turned out to be the shorter-stay, usual-practice facility would have reoffended on average sooner than those in the specialist facility. There was no such indication. Moreover, it was not just time which differed but intensity and content; whether more time in usual treatment would really have had magnified its impact to rival that of the more intensive and specialised regimen is an open question.

The authors' conclusions

Results from this study suggest that a parole therapeutic community adapted to their needs reduces recidivism among male former prisoners with substance use and mental health problems more effectively than the case management-based parole programmes typically implemented in Colorado. The adapted community retained its advantage whether or not the offender had been through the corresponding prison programme. However, best results of all came from the combination.

The implications are that criminal justice policy makers should consider developing post-prison modified therapeutic community parole programmes for these types of offenders, especially if they are unable to also mount similar prison programmes, though ideally both would be implemented. Similarly, even if the parole programme cannot be implemented, it remains worth implementing the prison programme.

In two respects however the impacts of the prison and parole programmes appeared to differ. The parole programme reduced criminal activity (especially alcohol- and drug-related offences) as well as reimprisonment, while the prison programme only substantially affected reimprisonment. One explanation could be that the prison programme did not stop a return to crime, but did reduce its severity enough to avoid some offenders returning to prison. Also, among those who were reimprisoned, only the prison programme extended their time free in the community.

Just what it was about the specialist parole programme which reduced reimprisonment rates is unclear. It differed not just in methods and content, but also in duration and intensity, though both the latter may be considered inherent consequences of methods and content.

FINDINGS Because of their randomised designs, the featured study and its predecessor are among the most convincing demonstrations of the benefits of organising prison and post-prison care along therapeutic community lines, but adapted for psychologically vulnerable offenders and with specific anti-crime components. Among the featured study's strengths were that it did not select its own participants but took any who met the prison system's criteria for continuing care and who agreed to join the study, and it did not rely for its results only on offenders who had completed the evaluated programme. Also the comparators were not no or minimal treatment, but significant programmes in their own rights, including a residential facility for continuing care.

About the featured study

Results are limited to men and those who entered prison with mental as well substance use disorders, but [this is the norm](#) for imprisoned dependent substance users in the UK. Of 512 offenders, 278 were at various stages considered unsuitable for release and/or for the continuing care facilities (or perhaps could not be accommodated), and another 92 refused to join the study, limiting generalisability to the entire male dually diagnosed Colorado prison population. Generalisability was not further eroded by offenders missing follow ups, a benefit of using official reimprisonment records.

It is worth stressing that offenders were required to attend both the specialist and the usual parole facilities as conditions of their parole from prison, and during their times there they were supervised by parole officers. Had they been free to choose, it seems likely that few would have accepted these continuing restrictions on their freedom, and without parole supervision, those who did might have been less engaged with the programmes. The result would probably have been that more would have ended up losing their freedom via a return to prison.

The authors were punctilious in noting that the apparent crime reduction effects of the specialist parole facility could not be attributed to its specialist programme, but might be due to duration and/or intensity. However, it was the flexibility and individualisation of the programme which appears to have extended its average duration, and unless the activities required of offenders are appropriate and acceptable to them, ramping up intensity is likely to result in higher non-attendance rates and no greater effectiveness. In other words, the retention-enhancing nature of the programme and its ability to engage offenders in intensive therapy may be inherent features rather than dimensions separable from content. Also indicating that content does matter is a study which compared two versions of a therapeutic community tailored for mentally ill and homeless problem substance users. Though similar in other ways, the less demanding of the two versions [much more consistently](#) improved on usual treatment.

Another possibility is that the more intensive continued care option led to fewer offenders being reimprisoned for new offences because more had already been returned to prison for violating the conditions of their parole, a [counter-intuitive finding](#) of at least one study. The featured study does not report how many offenders had their parole revoked for such violations, but since they stayed much longer in the specialist programme, revocation seems unlikely to be an explanation for the findings.

Freely available from the same research team is a [manual](#) for a therapeutic community of the kind evaluated in the featured study, but for homeless mentally ill problem substance users. The featured study's lead author also chaired a US expert panel which produced [guidelines](#) on the treatment of problem substance users with mental health problems.

Prison therapeutic communities

Arguably it is best where possible to use diversion programmes such as drug courts to avoid the imprisonment of offenders whose criminality is driven by substance use and to treat them under criminal justice supervision in the community. But if problem substance users are to be imprisoned, therapeutic communities [have a good record](#) relative to other approaches. On average though their effects remain modest, in one [meta-analytic](#) synthesis of the research [amounting to](#) about a 5% reduction in criminal recidivism compared to alternative or no treatment.

When the focus [is narrowed](#) to comparisons between minimal or no prison substance use interventions versus therapeutic communities, their average advantages in respect of crime and substance use after release are considerably greater. These advantages are substantially maintained even if offenders are forced to attend and in the most rigorous studies, though less promising studies may have failed to be published.

The role of post-prison continued care

The featured study was not a test of post-release continued care versus none, but of specialist, comprehensive and intensive continued

care versus a more usual case management-based approach. Some kind of throughcare is [widely considered important](#) to maintaining the gains made during prison treatment. However, [evidence](#) that this is the case is slim, though more convincing for therapeutic communities than for less intensive, non-residential post-prison care.

When results from the full range of evaluated continuing options are aggregated, versus alternatives for similar offenders they [have been found](#) to raise the anti-recidivism effect of prison therapeutic communities from about 5% to about 7%. [Another similar analysis](#) comparing prison therapeutic communities with minimal or no treatment found that mandatory continuing care on release made only a small and not statistically significant contribution to reducing crime.

The modesty of the overall added value from continuing care [may reflect](#) the lumping together of the less effective with the more effective programmes. Certainly the featured study and its predecessor suggest that part of the effectiveness of prison therapeutic communities is due to their promoting uptake of residential care after prison. If this is not available, the prison programme is robbed of one of its most important anti-crime levers. [Other studies](#) have gone further, suggesting that without continued care, prison therapeutic communities can be entirely ineffective.

Same picture for female offenders?

While women were not included in the featured study, across all studies they [have responded](#) at least as well as men to prison therapeutic communities in comparison with no or minimal treatment.

Some of the authors from the featured study have evaluated ([1 2](#)) a similar modified therapeutic community in a Colorado prison, but one tailored to its female problem substance users, most of whom had a history of and/or were suffering mental health problems. In the six months after release it compared well with the prison's usual cognitive-behavioural course for these offenders, which did not harness peer influence through group living arrangements and peer mentors and was more reliant on other prison services rather than itself offering a comprehensive programme. Though substance use was not significantly affected, fewer of the women who had been randomly allocated to the community later entered treatment for their substance use problems, their mental health improved more, and they were much less likely (9% v. 21%) to be arrested for a new offence.

Compared to a typical prison therapeutic community, a therapeutic community tailored for often psychologically disturbed female substance users [has been found](#) to lead after release to greater remission in drug use and problems and less risk of reimprisonment, perhaps partly because it meant the women were more likely to complete a residential continuing care programme. In some respects such as de-emphasising explicit confrontation and greater attention to mental health and trauma, [adaptations](#) of therapeutic communities for female offenders are similar to the adaptations made for male prisoners with mental health problems. In both cases there is reason to believe that the more confrontational and inflexible traditional community could be counterproductive.

British policy context

From the early 2000s [cognitive-behavioural group therapy programmes](#) have been relied on to improve the anti-offending record of UK prisons in general and in respect of drug/alcohol-driven crime in particular, but evidence has been scarce and generally negative.

While these courses are explicitly anti-crime, there is also a responsibility to organise health care in prisons equivalent to that available outside. Prison treatment and post-prison throughcare in England for problem substance use were reviewed by an independent commission instigated by government which published its [report](#) in 2010. It stressed that continuity of care as people pass in and out of the prison system is the critical issue. Priority post-prison needs include, the report said, housing, developing life skills, crisis support, peer support, and daytime activities to help make the transition to a normal life – needs which can be satisfied to a high degree by residential therapeutic communities.

At the time the report identified just five therapeutic communities for substance users in the 136 adult prisons in England and Wales. For this type of service (along with opioid substitution prescribing and intensive support/supervision on release) the experts found "particularly strong evidential support". However, post-prison continuing care was identified as the weak link, as it continued to be in the [2012 report](#) from the UK parliament's Home Affairs Committee.

As well as being few, a major limitation on prison therapeutic communities is that these are [usually reserved](#) for prisoners with at least 12 months left to serve, excluding many offenders with substance use problems.

NHS England is now responsible for commissioning prison treatment, including for substance misuse. Among other functions, [it is tasked](#) with ensuring that prison substance misuse teams focus on continuity of care for released prisoners, one of four "key service outcomes".

The featured study concerned what in Britain are termed dual diagnosis offenders. In 2009 the UK Department of Health and Ministry of Justice issued [joint guidance](#) on working with these offenders in prisons. Responsibility for coordinating care (including continuing care) for offenders with serious problems and/or who pose a risk to themselves or others, and who are therefore subject to the 'Care programme approach' (a proactive case management intervention), lies with their assigned coordinator in mental health services inside or outside prison. Other dual diagnosis prisoners are to be referred by prison health care staff to substance misuse and GP services in the community.

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