

CORRECTIONS REFORM & AOD SERVICES

What services must communities provide to maintain continuity of care and ensure offender success?

It is generally acknowledged, and multiple studies have shown, that at least 70% of the individuals incarcerated in California (including adolescents in juvenile detention) are harmfully involved with alcohol or other drug abuse, and in need of treatment. If they are not in custody because of a drug offense, often it is their substance abuse that contributes to or drives their criminal behavior. Moreover, a high percentage of the parolee population is returned to prison, often for technical drug-related parole violations.

There are three points where treatment intervention can be effective: (1) Post-conviction diversion programs, i.e. Prop. 36; (2) In-custody treatment; (3) Post-release, or aftercare programs, when individuals are released back into the community, and are in need of ongoing treatment/recovery services. In each of these, the treatment is usually provided by publicly-funded programs. Even so, only about 1 in 10 offenders who need AOD treatment is able to receive any treatment at all, much less an assessed or appropriate level of treatment.

The new AB 900 provisions for community-based re-entry facilities that will provide rehabilitative services will be an opportunity for local communities to provide treatment services for substance-addicted individuals coming back to their communities from incarceration. Some of these offenders may have received AOD treatment in custody, and are in need of continuing aftercare if they are to be successful in their recovery. In addition, aftercare should include those services essential to these individuals' successful reintegration into society. Among the services most urgently needed are thorough and accurate assessments, in order to discern what level and intensity of treatment is needed for each individual; integrated services for individuals with co-occurring mental health and substance abuse disorders; narcotic replacement therapy; vocational training; supportive housing, etc. Treatment should be matched and tailored to the patient's particular problems and needs, should be culturally competent, and should be based on a chronic care model.

Which agencies and what levels of government are best suited to provide services?

CADPAAC believes that all publicly-funded substance abuse treatment should be under the oversight of the single state agency, which in California is the Department of Alcohol and Drug Programs, and its local arms – the county AOD programs, which are best situated to provide substance abuse treatment, and to work collaboratively with other local agencies. This means that AOD treatment funds currently allocated to CDCR should be carved out and redirected to ADP, which would then allocate these funds to the local AOD programs that will be providing the treatment services for the offender population. Post-release (aftercare) treatment and re-entry services for substance abusers

should also be coordinated under the auspices of ADP and its county administrators. All of these in-custody, re-entry, and post-release treatment programs would benefit from being administered by treatment professionals rather than by a parallel treatment system that bypasses the established state/county structure. We believe that many of the problems identified by the recent Inspector General's report on in-custody AOD treatment could be addressed by such a restructuring. Moving a substantial number of the prison population into community-based treatment would also necessitate a partial transfer of responsibility for these inmates, along with resources, to the local level, in order to provide substance abuse treatment and related services.

How can county service providers best collaborate with state-run reentry facilities?

It is important that staff from AOD providers be located in the reentry facilities, in order to foster a treatment culture, as opposed to a punishment culture. Even those these will be locked facilities, they should be structured as secure treatment facilities, rather than as mini-prisons in which treatment is offered. Effective in-prison substance abuse treatment and aftercare represents one of the state's best hopes of reducing criminal behavior, decreasing recidivism, relieving the state's prison overcrowding crisis, and lessening the cost to society of criminal activity related to drug use and addiction. But we can no longer afford to bypass the AOD treatment and recovery field, who have the front-line expertise in treatment. County and regional partnerships can link offenders to services that support self-sufficiency, reduce re-incarceration, and improve public safety.

What are the "essentials" for effective treatment of the criminal justice population?

- A recognition that drug addiction is a chronic brain disease that affects behavior and, like other chronic diseases, is a relapsing condition that requires long-term relapse management and aftercare. (Let's stop using an acute care model.)
- Incentives for inmates to seek substance abuse treatment (i.e. a condition of eligibility for work assignments, discharge from supervision for the completion of established goals, etc.)
- Prompt access to treatment, both in-custody and post-release.
- Treatment duration of at least 90 days, to produce stable behavioral changes.
- Rehabilitation that maintains ties to the offender's community.
- An integrated treatment approach for offenders with COD.
- Use of a standardized assessment tool.

- A range of support services for offenders re-entering the community to prevent and treat serious, chronic medical conditions, such as HIV, Hep. C, and tuberculosis.
- Continuity of care in the community for offenders re-entering their communities – one year of primary treatment followed by 6 months of continuing care. Offenders who complete in-custody treatment should have a referral for continuing outpatient treatment in the community, including an initial appointment prior to release.
- A qualified, trained, and adequately-paid addiction professional workforce, both for in-custody and post-release treatment.
- Appreciation of partner agencies' responsibilities and an understanding of their limitations in providing AOD treatment to parolees and probationers.
- A funding allocation methodology that addresses unused funds and future funding reductions, and is endorsed by all stakeholders.
- Flexibility in the use of funding, so counties can address their unique needs in reducing recidivism.
- State investment in local programs and initiatives to supplement anti-recidivism efforts.
- Treatment should be defined by best practices as accepted by the AOD field, not by cost containment measures dictated by the Department of Finance.
- Clearly defined program goals and objectives that are communicated to state and local agencies.
- An evaluation plan to determine the impact of AOD treatment programs on recidivism.
- Standardized data collection.
- Monitoring of treatment providers using a standardized monitoring instrument, in order to provide quality treatment services to participants.