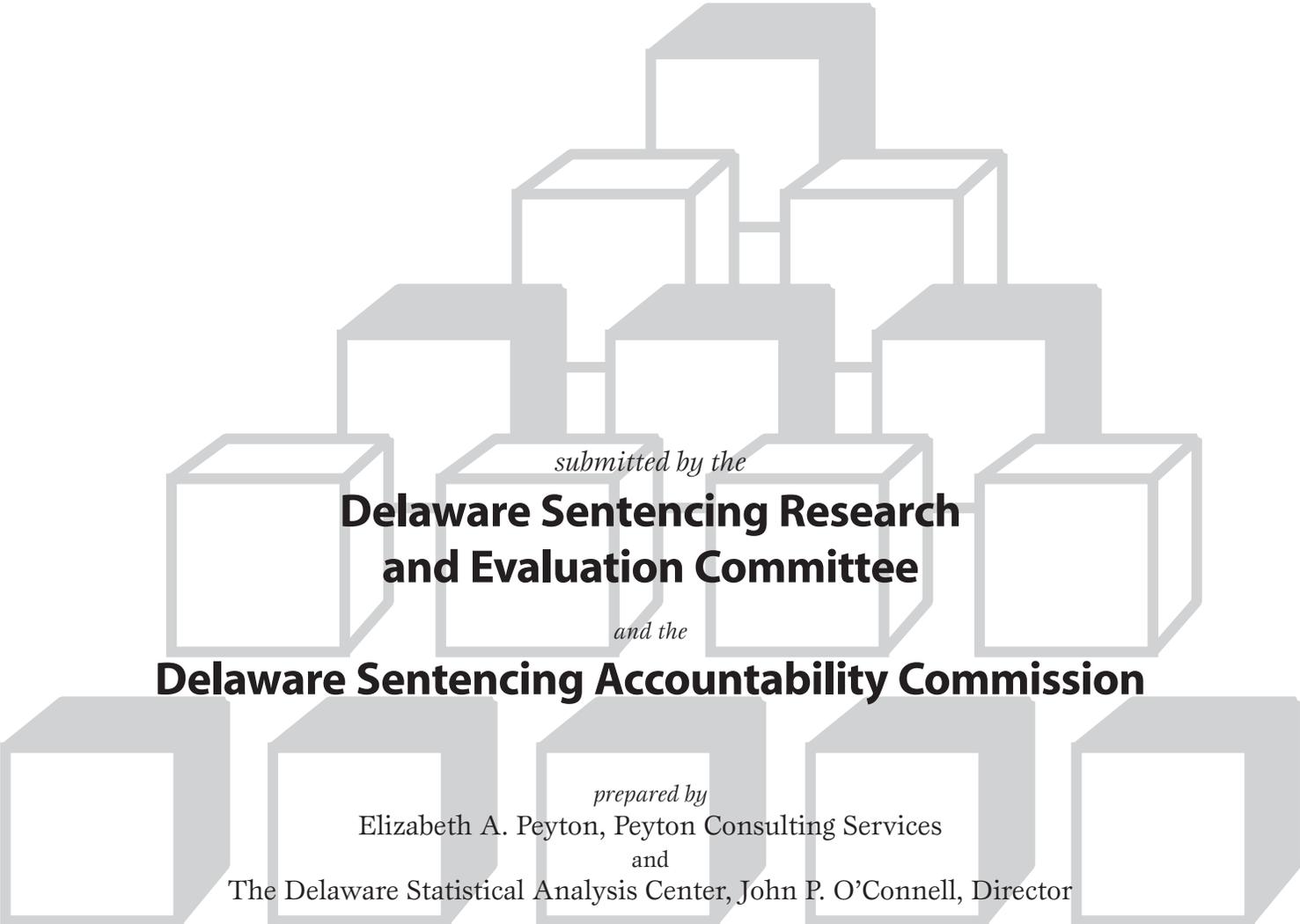


A Report to the Joint Finance Committee of the Delaware General Assembly

Correctional Treatment in Delaware: Strategies for Success

June 2004



submitted by the

**Delaware Sentencing Research
and Evaluation Committee**

and the

Delaware Sentencing Accountability Commission

prepared by

Elizabeth A. Peyton, Peyton Consulting Services
and

The Delaware Statistical Analysis Center, John P. O'Connell, Director

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The Delaware Sentencing Research and Evaluation Committee gratefully acknowledges all of those who contributed to the development of this report. Many staff in the Department of Correction and their contractors helped us track court-ordered offenders into treatment programs and understand the paths offenders take along the way.

Judges and judicial officers from the Superior Court, Court of Common Pleas, and Family Court took time out of their busy schedules to complete our survey, and the Superior Court allowed us to discuss our findings with them during their busy retreat. The results of the survey gave us insight and provided a policy framework for understanding some operational issues, and underscored the importance of effective treatment in Delaware’s sentencing and correctional system.

Beth Peyton and the team at the Statistical Analysis Center worked to produce the draft report. Beth served as the primary report developer, and Charles P. Huenke from the Statistical Analysis Center spent countless hours analyzing the judicial survey and tracking offenders. John P. O’Connell, Director of the Statistical Analysis Center, helped shape the report and asked the difficult questions to turn the findings into a policy document.

Members of the Committee, Judge Richard Gebelein, Commissioner Stan Taylor, Bryan Sullivan, Evelyn Nestlerode, and Gail Riblett thoughtfully discussed the findings, and reviewed and shaped the final product. It has been my great pleasure to work with this team. Members of the Sentencing Accountability Commission were also particularly helpful in their comments and analysis of the draft of the report.

The Joint Finance Committee of the General Assembly, the Office of the Controller General and the Office of the Budget graciously made this work possible. Their continued interest in justice and sentencing policy keeps Delaware in the forefront of the nation.

David S. Swayze
Chairman
Delaware Sentencing Research and Evaluation Committee

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Executive Summary

This report is designed to augment the Delaware Sentencing Research and Evaluation Committee's 2002 report, *Sentencing Trends and Correctional Treatment in Delaware*, by further exploring issues related to treatment for adult offenders and its impact on the justice system. It provides a summary description of current treatment programs for correctional populations; an overview of major issues and trends related to providing correctional treatment in Delaware; an analysis of Delaware's system of providing treatment services to offenders as compared to research-based standards and practices; an analysis of treatment placement issues from a sample of offenders court-ordered to treatment; results of a survey of the judiciary regarding sentencing practices for adult substance-involved offenders; and recommendations for system improvement.

Over the last decade, Delaware has made a substantial investment to provide substance abuse treatment services for adult offenders. Expansion of services in Level V was designed to provide substance abuse treatment for a significant number of inmates with substance abuse problems. Proportionally, Delaware provides more treatment for incarcerated offenders than any other state, and despite its size, in 2000, ranked 8th in the nation in absolute number of treatment beds in correctional facilities. CREST programs were established to provide transitional services for KEY graduates as well as for Level IV offenders, and have been expanded based on research findings that demonstrated positive outcomes for offenders who participate in a planned continuum of care. Community based residential services have also expanded (although not as rapidly), and provide services to Delaware's substance-involved offenders.

The attention that the Delaware judiciary pays to treatment issues, reflected in their sentencing practices as well as their interest in treatment policy, represents a fundamental shift from sentencing practices that existed prior to the mid-1990s. Under SENTAC, punishment and treatment are coexisting goals, and by incorporating conditions for treatment into criminal sentencing, judges are allowed to balance the need for punishment, as outlined in sentencing guidelines, with the need for treatment on an individualized basis. It is difficult to find any other state jurisdiction where support for rehabilitation and recovery from substance abuse is so widespread throughout a justice system and among policymakers.

An analysis that tracked 153 offenders court-ordered into Level IV or V residential treatment showed that three-quarters of the cases examined were admitted to the court-ordered program or an alternative program within the study period. Of these, half were admitted within 28 days, with the rest placed between five and twenty-seven weeks. One quarter of those court-ordered to treatment were not placed during the study period. Reasons for delayed placement or for not being placed at all include offenders serving long term sentences, having pending charges, violating their probation sentences before being admitted, refusing or being inappropriate for treatment, or other reasons.



Operating and accessing treatment services inside a sentencing and correctional framework presents a number of challenges. Different styles of sentencing and conflicting sentences are common, and there is no standardized process for reconciling these conflicts. There are competing paths to admission, including DOC classification, court orders, self-referrals, and referrals by others in the justice system, and offenders are competing with the general public when accessing community-based residential services. Admission delays result in large part from a lack of information as offenders are being processed through the criminal justice system.

Delaware's system for placing court-ordered offenders into treatment basically relies on paper and informal communication. Computer systems between the courts and Department of Correction are not well linked, and are not integrated at all with treatment data systems. It works as well as it does because people in the system are dedicated to providing treatment for offenders, and because court orders receive a high priority by the DOC. There are a variety of people and agencies responsible for moving offenders into treatment, and placement occurs for the most part in the absence of formal policies or procedures.

Fifty-three percent of Delaware judges and judicial officers from the Superior Court, Court of Common Pleas and the Family Court responded to a survey on adult offender treatment services. The survey revealed that judges' sentencing practices are influenced by the availability of treatment, and that judges' sentencing practices would likely change if treatment availability changed. Judges called for more residential services in the community, and indicated that they would sentence fewer people to Level V if effective community-based residential services were more available. Judges also indicated they have a high propensity to order treatment when they believe an offender is substance-involved, but the information they need to make these determinations is largely unavailable at sentencing.

Under Delaware's structured sentencing system, judges fashion sentences designed to meet multiple goals. Unless they are confident that conditions for treatment will be met in a timely fashion and that positive treatment results will occur, judges are likely to choose higher levels of supervision to protect the safety of the public.

Concerns have been expressed by members of the judiciary and others regarding whether or not judges should sentence offenders to specific treatment programs in the first place. While treatment placement and activities are arguably clinical in nature, clinicians and treatment experts cannot work in a vacuum when dealing with offender clients. If people are committing crimes serious enough to come under the jurisdiction of the Superior Court, treatment placement and participation are no longer simply clinical issues. Failing to incorporate justice system issues and involvement would remove the powerful leverage and incentives that the justice system can offer to promote offender client engagement and retention, and obtain positive outcomes.



The literature shows that a number of factors are critically important when developing a systematic and effective process for providing substance abuse treatment for offenders. They include:

- Effective processes for screening and assessment;
- Comprehensive treatment planning;
- A range of treatment options;
- Programming of sufficient length and intensity;
- A range of supervision options;
- Continuity of care;
- Management information systems for tracking and managing offender treatment; and,
- Performance evaluations.

When comparing Delaware practices with these factors, Delaware falls short in some areas. Although clinical assessments appear to be routinely conducted, assessment information is not generally available at time of sentencing, and is not always used to develop differentiated treatment plans designed to meet the needs of individual offenders.

Delaware has established a continuum of long term and intensive treatment with the KEY and CREST programs, but the extent to which this continuum is used as designed is unknown. In addition, judges indicated a need for more community-based offender treatment, along with more choice in terms of program approach. Communication and information management and exchange capabilities have not kept pace with the rapid expansion of the treatment system, and are not sufficient to accommodate the many ways offenders enter into and participate in treatment, nor to regularly evaluate these programs.

Delaware has numerous strengths in which practitioners and policymakers should take pride. The proportion of offenders able to access treatment, especially in Level V, is unmatched by any other jurisdiction. There is system wide support for offering treatment as a means to interrupt the criminal activity of substance-involved offenders. The Department of Correction and the judiciary are fully engaged in this effort, and over the years have advocated for and responded to a substantial increase in the number of services for offenders.

To implement and operate effective systems of services for substance-involved offenders, policy makers must move beyond the simple question of “does treatment work?” to examine *what treatment and supervision interventions work best for what types of offenders*. While Delaware is doing a good job of identifying offenders with substance abuse problems and placing them in treatment, the system is not doing a good job of identifying *which offenders are appropriate and amenable for different types of treatment*.



The opportunity to rehabilitate offenders is very important to Delaware judges, correctional and other justice professionals, and policymakers. This is clearly evidenced by the level of funding and interest that correctional treatment has engendered over the last several years; by the efforts that staff make to secure treatment within a system that is not well equipped to support those efforts; and by a judiciary that tells us that the need for treatment overrides the punishment aspects of sentencing in many cases. The system has evolved to a point where establishment of an infrastructure and capacity to manage treatment services for adult offenders more effectively is overdue.

Recommendations

1. ***Establish a system of screening and assessment so judges can order treatment conditions based on both the clinical and risk characteristics of offenders.***

A system of screening and assessment should be established under the aegis of SENTAC, so judges can order treatment conditions based on both the clinical and risk characteristics of offenders. This information should be available for making sentencing decisions for both new crimes and probation violations. To accomplish this, priority populations of offenders who should receive substance abuse treatment services should be established. These populations should be defined in accordance with correctional and sentencing policy, as well as program design, capability and capacity. Resources that are currently devoted to this up-front work should be identified and evaluated, and shifted as necessary to accomplish this goal. The system should be designed to capture assessment information on the bulk of appropriate treatment candidates without causing delays in case processing, while encouraging more appropriate treatment and supervision.

2. ***Expand community-based services for substance-involved offenders to include residential and intensive outpatient services.***

Community-based services specifically for substance-involved offenders should be expanded to include residential and intensive outpatient services. Any new residential programming should include transitional care (perhaps in the form of intensive outpatient treatment) and aftercare in the original design. Consideration should be given to creating longer term correctional TCs in the community to provide initial care. CREST could then be used to provide transitional services as designed. This would have a positive impact on the use of Level V beds and support offender movement through a planned treatment continuum.



3. *Examine outcomes of Level IV and V correctional and community-based programs.*

Additional research should be conducted by the Delaware Sentencing Research and Evaluation Committee and the Statistical Analysis Center to examine outcomes of Level IV and V correctional treatment programs. Likewise, long-term outcomes for Level IV offenders placed in community-based residential treatment should be studied. Research should examine both clinical and justice characteristics of research subjects to begin to determine the *types* of offenders that respond best to different treatment interventions. Close examination of the processes in which offenders move through the treatment continuum should also occur. This research should inform policymakers in reallocating treatment resources to serve the most clients using evidence-based treatment practices while producing the best outcomes and conserving correctional resources.

4. *Develop policies, procedures, inter-agency agreements and data capabilities for managing substance-involved offenders.*

A process should be initiated under the aegis of SENTAC to develop policies, procedures, inter-agency agreements and data capabilities for managing Delaware's substance-involved offender population. To begin this work, an endeavor to educate a wide range of justice and treatment practitioners concerning evidence-based practices for substance-involved offenders to develop a common understanding of and vision for improving offender treatment systems and services should be supported. The Delaware Sentencing Research and Evaluation Committee is currently identifying resources that could be used to begin this process.

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**CORRECTIONAL
TREATMENT
IN DELAWARE:**

**STRATEGIES
FOR SUCCESS**

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Introduction

In April 2002, the Sentencing Accountability Commission's Sentencing Research Committee released a report entitled *Sentencing Trends and Correctional Treatment in Delaware*. This report described Delaware's system of correctional treatment, and presented a comparative analysis of program outcomes in the KEY, Greentree, and CREST programs.

While all programs showed moderate reductions in recidivism (as measured by felony arrests), rates of violations of probation were high. In general, policymakers agreed that outcomes in correctional treatment programs warranted improvement and that the system for providing treatment services for correctional populations should continue to be examined.

Accordingly, this report further explores issues related to treatment for adult offenders and its impact on the justice system. It provides:

- ❑ A summary description of current treatment programs for correctional populations;
- ❑ An overview of major issues and trends related to providing correctional treatment in Delaware;
- ❑ An analysis of Delaware's system of providing treatment services to offenders as compared to research-based standards and practices;
- ❑ An analysis of treatment placement issues from a sample of offenders court-ordered to residential treatment;
- ❑ Results of a survey of the judiciary related to offender treatment practices; and,
- ❑ Recommendations for system improvement.

Background

In 1987 the SENTAC structured sentencing system went into effect in Delaware. A five-level system of sanctions, ranging from Unsupervised Probation (Level I) to Incarceration (Level V) was established, with sentencing standards and principles developed to guide judges to sentence offenders along the supervision continuum based on their crime and criminal history. Truth-in-Sentencing, which restricted early release mechanisms and standardized the percentage of time served in a correctional facility at 75 percent of the original sentence, was enacted in 1990 to further improve sentencing equity. The overall goals of SENTAC, as established by the General Assembly and listed in priority order, are to:

1. Incapacitate the violence-prone offender;
2. Restore the victim; and,
3. Rehabilitate offenders.



The system was designed to allow the judiciary to reserve incarceration for the most serious and recalcitrant offenders to minimize prison costs while maximizing opportunities for rehabilitation. Since the inception of SENTAC, the goal of offender rehabilitation has gained prominence in the system. Sentences to any supervision level can (and often do) contain conditions for participation in substance abuse and other treatment.

This report is presented in several discrete yet related sections. The first section presents a summary of services and activities aimed at reducing substance abuse in the offender population in Delaware. Section II presents an overview of evidence-based practices – approaches and techniques that have proven effective for substance-involved adult offenders. Section III presents results of a study that examined the processes related to placing court-ordered offenders into residential treatment services in Delaware. Section IV presents results from a survey of the Delaware judiciary on their practices, attitudes and opinions related to substance-involved offenders. Section V contains overall conclusions and recommendations for improvement to Delaware’s system of managing substance-involved offenders.



Section I : Services and Activities

Both the Department of Correction (DOC) and the Delaware Department of Health and Social Services' Division of Substance Abuse and Mental Health (DSAMH) operate substance abuse treatment services through contracts with a number of private providers. In addition, other programs have been designed to focus on substance-involved offenders. This section contains a brief summary of major program efforts as well as an overview of new and pending programs.

Corrections-Based Substance Abuse Programming

Over the last decade, Delaware has made a substantial investment to provide substance abuse treatment services for adult offenders. The KEY program, which began as a pilot project at Gander Hill prison (now the Howard Young Correctional Institution), rapidly expanded to a peak capacity of nearly 600 beds, serving both men and women at Level V (incarceration). This Level V expansion was designed to provide substance abuse treatment for a significant number of inmates with substance abuse problems. Proportionally, Delaware provides significantly more treatment for incarcerated offenders than any other state, and despite its size, ranked 8th in total number of treatment center beds in correctional facilities in absolute number of treatment beds (Kressel et al., 2002)¹.

The CREST program was developed to provide transitional treatment services and work release, and based on positive research results (Martin et al., 1999) expanded to approximately 400 beds to serve an annual capacity of about 800 people. CREST began accepting direct Level IV admissions soon after its inception. To accommodate for the fact that these admissions had not previously completed a KEY program, new admissions are now required to participate in New Horizons, located at the Central VOP Center, to become stabilized and oriented prior to entering CREST. An aftercare program was established to provide outpatient services for graduates of KEY and/or CREST. Programs also allow for "tune-ups" whereby program graduates are readmitted for a short period of time to stabilize after a relapse.

During 2003 the Department of Correction awarded a contract to Civigenics to provide correctional treatment in the KEY and CREST programs, previously operated by Correctional Medical Services. As part of the new contract, the bed capacity in the KEY program has been reduced to about 400 beds, and KEY services are no longer provided at Webb Correctional Facility. The number of CREST beds was expanded to around 500 to serve an annual capacity of about 1000 people, and aftercare slots have been set to serve about 600 people annually.

The Greentree program, established in the 1970s, developed into a 175 bed therapeutic community at Delaware Correctional Center (DCC) during the 1990s. Plans are underway by the Department of Correction to establish another Greentree-like program at Sussex Correctional Institution.

¹ Only California, Texas, Virginia, New York, New Jersey, Missouri and Florida have more inmate treatment beds.



KEY is designed to coordinate graduation with release from Level V, supporting the opportunity for offenders to move through CREST and aftercare. On the other hand, Greentree graduation, with the exception of the “accelerated” program, is not tied to institutional release. Although transitional treatment and aftercare would improve Greentree outcomes, the program design itself is effective given the function of Greentree at the Delaware Correctional Center. Greentree is an important component of institutional management at DCC. Many people are moved to minimum classification upon Greentree graduation who otherwise may have been disciplinary problems (requiring more secure and costly housing).

Although it operates out of the Howard Young Correctional Institution (formerly “Gander Hill”), the “Six for One” program is operated by Civigenics via contract with the Division of Substance Abuse and Mental Health (DSAMH). The program is funded from the Edward Byrne Memorial grant through the Criminal Justice Council, and is designed to provide assessments and up to 45 days of treatment for detainees.

The Women’s Treatment Center at the New Castle County Women’s Work Release Center is scheduled to become operational in the fall of 2004. The 96-bed program for women will be modeled after the CREST program, and will provide transitional treatment for women graduating from KEY Village, and primary treatment services for women sentenced to Level IV. The program will be located adjacent to the Baylor Women’s Correctional Facility, and Elizabeth Neal has been selected to be the deputy warden in charge.

The Department of Correction has established contracts with several providers statewide to deliver outpatient treatment services for offenders in Level III. Approximately \$400,000 goes to deliver substance abuse evaluation and outpatient treatment services, as well as programming for domestic violence perpetrators and sex offenders. Ongoing general state funds as well as an annual allocation from the Substance Abuse Rehabilitation, Treatment, Education and Prevention (SARTEP) fund support these efforts.

The Department of Correction also operates a number of other institutional and community-based programs aimed at substance abuse, violence reduction, employment, residential stability, educational improvement, mental health, and life skills.

Community-Based Programming

Community-based programs for adults have expanded more slowly over the years. Much of the expansion has resulted from increases in state funding to accommodate offender clients, and most recently, to treat Delaware’s growing population of heroin users.

The Division of Substance Abuse and Mental Health (DSAMH) contracts with a number of organizations to provide residential and outpatient substance abuse treatment services, and very recently reorganized residential treatment services located at the Governor Bacon Campus in Delaware City. While none of these programs are designed specifically for offenders, DSAMH estimates that



approximately 80 percent of clients in outpatient services and 50 percent of clients in residential programming are either referred by the justice system or on active correctional supervision.

Gateway is the new contractor responsible for providing residential services at the Governor Bacon Campus in Delaware City. The reconfigured 80-bed program is designed to be 90 days in length, although length of stay will depend on the needs of each client. According to DSAMH, the program will provide motivational enhancement therapy, cognitive behavioral therapy and relapse prevention in a therapeutic milieu for men, along with a program for women.

Gaudenzia, Inc., a large treatment provider headquartered in Pennsylvania, has recently opened a residential treatment program in Newark. The 20-bed Fresh Start program is a 6-month therapeutic community designed for young adults (18-25), and is aimed primarily at opiate addicts. The program will accept referrals from the criminal justice system, including court-ordered offenders.

DSAMH also contracts with several organizations that provide detoxification services, methadone maintenance, day treatment, outpatient treatment, and recovery-based halfway house services in all three counties.

Other Programs

Several other programs and interventions operate to organize or provide services for Delaware's substance-involved offender population. Delaware's drug court became fully operational in New Castle County Superior Court in 1994, and was expanded to all felony courts statewide in 1997. The drug court was designed to provide services and judicial monitoring for first-time and low-level drug offenders (Track II) who were diverted from further prosecution, and who had their charges dropped if they successfully completed drug court. In addition, the drug court established Track I, targeting persons who committed a new crime while on probation from Superior Court. In Track I, participants receive case management by the Treatment Access Center (TASC), may receive more intensive treatment services (including residential and in-custody programming), and are sentenced, with treatment completion generally resulting in shorter prison or jail stays. The Court of Common Pleas also operates drug courts to divert misdemeanor offenders in New Castle and Sussex Counties, and plans to implement drug court in Kent County are underway.

The Treatment Access Center (TASC) was also established in the early 1990s, and developed in conjunction with the drug court. TASC, a national model program, is designed to engage persons referred by the justice system to substance abuse treatment and other services, and to collaborate with both justice and treatment to ensure that appropriate and adequate services are available for justice clients. According to the TASC Guide for Practitioners and Policy Makers (Peyton, 2001), "TASC spans the boundaries of both the treatment and justice systems by identifying appropriate treatment referrals through clinical screening processes, assessing the



treatment and other needs of clients from the justice system, referring clients to treatment and other services, and providing client-centered case management to ensure that clients are admitted, engage, remain in, and benefit from treatment.”

DSAMH received \$2 Million in federal grant money over a three-year period to support The Serious and Violent Offender Reentry Initiative. Designed to provide a continuum of focused services and supervision to offenders between 18 and 35 years of age who are being released from a Level V facility, the program represents a collaboration among DSAMH, DOC, the Department of Labor, and many other agencies and provider organizations. Assessments are conducted and case plans are developed while offenders are still incarcerated, and offenders are transitioned into community-based services with close case management and judicial oversight. The goal is to sustain ex-offenders in the community through continued community support, treatment and monitoring. The first cohort of offenders eligible for this program has been identified.

Delancy Street, a self-help therapeutic community program based in San Francisco, California and operating at four sites around the country, has expressed an interest in developing a program in Delaware. Several Delaware inmates will be selected to participate in Delancy Street’s New York program for several years, and then will comprise the core group of Delancy Street residents once a local program site has been established. Delancy Street focuses on personal responsibility and work ethic, and residents are involved in the development and operations of several businesses.

Reentry court, a pilot project of Superior Court in New Castle County, began in August 2000. This program targets offenders being released from prison for enhanced treatment services and intense supervision. Using a dedicated TASC case manager and specially assigned probation officers, it places offenders reentering the community after incarceration in an appropriate treatment program as well as numerous ancillary services.



Section II: Overview of Evidence-Based Practices

Over the last twenty years, empirical evidence has clearly shown that substance abuse treatment works for offenders and other client populations (Simpson et al., 1997; Taxman, 2002; Mears et al., 2003), and that treatment is a vital component of effective efforts to deter and change criminal behavior (Petersilia, 1999). However, to implement and operate effective systems of services for substance-involved offenders, policy makers must move beyond the simple question of “does treatment work?” to examine *what treatment and supervision interventions work best for what types of offenders*. Systems need to be designed to have the maximum impact on reducing relapse and criminal recidivism and provide the greatest benefit to public safety. Likewise, public safety and public health resources need to be wisely allocated to achieve the best outcomes possible.

Like many other states, Delaware has invested substantial resources to provide substance abuse services for offenders in correctional settings, and with upwards of 80 percent of offenders needing substance abuse treatment (Bureau of Justice Statistics, 1999; Delaware Treatment Access Committee, 1994), this is a wise decision. In addition, many offenders participate in programming that is managed by the public health system through the Substance Abuse and Mental Health (DSAMH).

Even though a tremendous amount of research has been and is being done in the area of substance abuse and correctional treatment, there is no definitive guide to best practices. However, much of the literature consists of common elements and themes that support the delivery of effective treatment for offenders and other clients.

The National Institute on Drug Abuse has defined 13 fundamental principles that characterize effective drug abuse treatment, and much of the scientific research that supports these principles was conducted with offender clients (National Institute on Drug Abuse, 1999). These principles are shown on the following page.



1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.**
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.**
4. **At different times during treatment, a patient may develop a need for medical services, family therapy, vocational rehabilitation, and social and legal services.**
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs..... Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.**
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.**
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.**
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.**
10. **Treatment does not need to be voluntary to be effective.**
11. **Possible drug use during treatment must be monitored continuously.**
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.**
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.**



Within the general framework of the NIDA principles, a number of other factors are critically important when developing a systematic and effective process for providing substance abuse treatment for offenders.

Effective processes for screening and assessing offenders

For programming to be effective, offender clients must be properly screened and assessed to develop a treatment plan and match clients with appropriate programs and interventions. Screening is a brief process designed to determine eligibility and appropriateness for treatment, and can be performed by trained non-clinicians. Several screening instruments have been validated with offender populations (Peters et al., 2000)².

Assessment is an ongoing process designed to diagnose specific problems, match clients with particular services, and develop and update treatment plans. The most widely used instrument for diagnosing substance abuse disorders is the Addiction Severity Index, or ASI (Peters and Peyton, 1998). Assessments should be conducted by qualified persons and are typically conducted by certified substance abuse or addiction counselors, social workers, psychologists and clinical nurse specialists (Peters and Peyton, 1998). Assessments for offenders should include, at a minimum, chemical dependency status, justice involvement and justice history, and social history. Information should be verified with collaterals (e.g. justice files, probation officers), and should be accompanied by drug testing results when possible.

The prevalence of mental health disorders among criminal justice populations is higher than among general community samples. The National GAINS Center has estimated that approximately 40-50 percent of substance-abusing offenders have a major mental illness (National GAINS Center, 1997). Therefore, offenders should be screened for mental health disorders, and when appropriate, receive full mental health assessments.

Even within a structured setting, such as a therapeutic community or a drug court, differentiated clinical and supervisory strategies must be used to encourage engagement and retention in treatment, and to obtain desired outcomes.

When systems fail to do an adequate job of screening and assessing offenders, they may place the wrong people in the wrong programs, fail to address the full range of needs of those admitted, lose the ability to document and monitor the substance abuse and other needs of offenders, and obtain poor treatment outcomes.

Comprehensive treatment planning

Substance involved offenders often have multiple needs. There are high rates of co-morbidity (co-occurring mental health and substance abuse disorders) in the offender population, as well as educational and employment deficits, health, social

² Preferred instruments include the Alcohol Dependence Scale and the Drug Use section of the Addiction Severity Index; the Texas Christian University Drug Dependence Screen; and the Simple Screening Instrument.



and other problems. Addressing these issues to achieve both sobriety and social stability is critical, particularly for those offenders who are transitioning from incarceration and who may have lost any previously available social support.

Research has shown that clients appropriately matched to treatment are more motivated than those placed in any available program because they stay longer, experience fewer negative discharges, and perform better on a range of outcomes (Mears et al., 2003). Treatment outcomes are also better if *characteristics of the offender* (e.g. level of substance abuse, relationship of substance abuse to criminal behavior), rather than simply *characteristics of the offense* (e.g., arrested for a drug crime) are used as criteria for treatment eligibility (Taxman, 2004).

A range of treatment options

A range of treatment options should be in place to meet the needs of offender clients. No single program approach works for everyone.

Therapeutic communities (TCs) have become the program model of choice for many corrections departments across the country. TCs were originally designed as peer-directed self-help programs designed to “habilitate” persons with serious substance abuse and criminal backgrounds, who had never developed or who had lost a commitment to prosocial values. They were designed to be long-term, hierarchical, and confrontational, with much of the clinical activity occurring among the residents. Activities in TCs are designed to evoke feelings and emotions among residents who may have buried any feelings (except anger) for a long time.

Some offenders respond to programming that is generally based on the 12-Step or Minnesota model. Based on the AA philosophy of alcoholism or drug addiction as a chronic, progressive spiritual and medical disease, program goals for recovering individuals include complete abstinence from substances (Rounds-Bryant et al., 2000). The 12 steps describe actions and beliefs that persons can follow to achieve long-term recovery. This approach incorporates clients into a recovery fellowship that is available after treatment discharge and emphasizes a broad array of recovery tasks; cognitive, spiritual, and health. This approach has been shown to be effective with clients from diverse backgrounds, and is probably the most common form of intervention (Taxman, 2002).

Cognitive behavioral approaches consistently appear to be the most effective treatment therapy for substance abusers (Taxman, 2002). The cognitive behavioral model views substance abuse as functionally related to problems and situations in the individual’s life, and trains clients in intra-and interpersonal skills that reduce relapse risk, maintain abstinence, and enhance self-efficacy. Clients are taught coping and problem-solving skills, and identification of triggers that lead to relapse. This approach may require basic literacy skills and higher cognitive functioning.

Most programs use a combination of the above techniques when treating clients.



Programming of sufficient length and intensity

In addition to variations in clinical approaches, it is important to offer treatment in a range of structures and settings and with varying degrees of length and intensity to meet the varying needs of offender populations. Consideration should be given to needs at initial treatment intervention, as well as support needs during transition following program completion.

A number of studies have shown that length of time in treatment seems to be the most salient variable related to successful treatment outcomes. According to the National Institute on Drug Abuse, “Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment. However, research has shown that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years (National Institute on Drug Abuse, 1999). A study by McLellan et al. (2000) found that approximately 50 percent of clients who complete 12 months or more of drug abuse treatment remained abstinent for an additional year after completing treatment. According to Faye Taxman, the goal for correctional treatment should be to engage offenders in treatment for longer periods of time by combining intensive and less intensive services (Taxman, 2000).

Likewise, outpatient treatment needs to be of sufficient length and intensity to engage offenders and to achieve positive outcomes. Several studies have shown that drug focused group counseling and psychoeducational groups by themselves are not effective for substance-involved offenders (Pearson and Lipton, 1999, Marlowe et al., 2003). A range of residential and nonresidential programming should be in place in both institutional and community-based settings to meet the needs of offender clients. Longer term residential treatment should be reserved for people with severe and chronic substance abuse problems and for people who cannot achieve recovery in their current living environments. While a continuing trend in the field is minimizing services and reducing the length of time clients are in treatment (Etheridge et al., 1997), providing offenders with treatment of sufficient length and intensity, combined with transitional and recovery support services, is likely to produce the best results.

A range of supervision options

A range of supervision options also needs to be in place to provide appropriate structure and accountability, and to support treatment progress. The level of treatment needed does not necessarily equate to the amount of supervision an offender may require. For instance, a low level offender may need residential treatment services and minimal supervision, while a high level offender who may require intensive supervision may not need substance abuse treatment at all.



Regular and frequent drug testing is an important supervisory function for offenders in treatment. Drug test results can be used to monitor compliance, identify when a relapse has occurred, or identify when treatment intensity needs to be increased for the offender to progress. In addition, supervision officers need to monitor compliance with treatment attendance, and facilitate the treatment admission process. Supervision officers can also provide additional support during transitions in treatment, and when gaps in treatment occur.

The intensity of supervision can add to or detract from success in treatment. In a recent study of Delaware's drug court, high-risk³ offenders performed much better in drug court when subjected to frequent status hearings, and low-risk offenders actually did worse when subjected to intensive drug court supervision (Marlowe et al., 2003). This study provides further support for using a differentiated approach based on the nature of the risks and needs individual offenders present.

Continuity of care

Another consistent finding in the treatment literature on offenders is that outcomes improve significantly with the addition of transitional care and aftercare following residential treatment, including institutional, prison-based treatment. Several studies have indicated that superior outcomes are achieved when inmates complete all phases of planned treatment, including aftercare (Martin et al., 1999; Rounds-Bryant et al., 2000).

One of the keys to retaining offenders in treatment and encouraging participation throughout the treatment continuum is effective case management. Perhaps the most well known case management approach for offenders is TASC (Treatment Accountability for Safer Communities). In Delaware, TASC services are provided by the Treatment Access Center out of the Division of Substance Abuse and Mental Health. Primary functions of TASC case management include screening and assessment; referral and linkage to service; ensuring admission; monitoring progress, including conducting drug and alcohol screening; and providing advocacy. Although TASC in Delaware has not been evaluated, nationally TASC and other forms of case management have been shown to be effective (Center for Substance Abuse Treatment, 1998). TASC clients in Birmingham, Alabama and Chicago, Illinois showed reductions in both drug use and drug crimes compared to control groups, and had the strongest effect on the most problematic offenders (Turner and Longshore, 1998). TASC has been shown to increase client retention when compared with non-TASC clients, and length of time in treatment has been shown to be a consistent predictor of treatment success (Hubbard et al., 1989).

In addition, multiple interventions may be required to achieve success. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact (National Institute on Drug Abuse, 1999). However, this does not necessarily mean that clients should be readmitted to the same programs multiple times. Rather, relapses of previously stabilized clients and program graduates should be handled by

³ High-risk offenders included those who had previously failed in treatment, or who were diagnosed with an anti-social personality disorder.



short stays in intensive services, followed by longer stays in transitional and aftercare services, combined with sanctions and incentives to promote compliance and progress.

Management information systems for tracking and managing offender treatment

Data regarding offenders in treatment need to be collected and managed to provide ongoing information for policymakers and practitioners, and to support changes in the treatment system. The following data elements are essential to manage offenders in treatment, as well as offender treatment systems:

- Admissions
- Screening/assessment status and results, including a list of those pending assessment
- Characteristics of those admitted, including substance abuse severity, criminal status and history, social history, prior treatment and justice activity
- Characteristics of those who are rejected
- Parameters of current sentence
- Discharge status
- Transfer status (for example, was the person transferred to aftercare)
- Supervision requirements, including current supervision officer
- Case management status and current case manager
- Waiting list information and other barriers to admission

Without this information, policymakers cannot determine whether the right people are being referred and admitted to the right programs, cannot assess offender needs that are not being met (mental health services, for instance), and cannot plan program additions or modifications reliably. Policymakers need to know if programs are over- or under-subscribed, whether some programs have higher than expected dropout rates, the characteristics of persons who are rejected from treatment, and the general substance abuse status of offenders on an ongoing basis. In addition, if these basic records are not kept accurately, it is very difficult and resource-intensive to conduct program evaluations.

Performance evaluations

Offender treatment programs need to be evaluated on an ongoing basis to determine whether programs are effective and if the system is working as designed or optimally. Process evaluations can be effective in determining the kinds of program changes that need to be made to improve outcomes, and to document implementation issues for new programs (so any problems can be avoided in the future).

Outcome evaluations are critical to determine if programs are performing to expectations, as well as to encourage modifications when they are not. Often, major changes are made to programs or treatment systems without an examination of program effectiveness. In addition, programs that have been successful in the past may change (or the types of offenders who are admitted may change), and they continue to be used even though they are no longer performing adequately. Funding should be structured to provide incentives to programs that produce positive outcomes.



Analyses should also be conducted to determine the costs and benefits of providing substance abuse treatment and other services to offenders. Policymakers need to be sure that offenders are not *unnecessarily* incarcerated to participate in prison-based treatment, and that programs designed to divert offenders from prison or jail are, in fact, admitting that target population.

Barriers to Success

Implementing successful treatment programming for offenders is difficult, and without an adequate infrastructure the likelihood of sustained positive results is diminished. Faye Taxman identifies a variety of barriers that have been identified in the literature (Taxman, 2000). They include:

- Lack of clear crime control goals for treatment services;
- Lack of clear assessment and eligibility;
- Insufficient duration of treatment for offenders to effect behavioral change;
- Lack of supervision and sanctions/rewards to reinforce treatment goals;
- Lack of objective drug testing to monitor progress in treatment; and,
- Insufficient case management services.

For institutional programs, barriers to effectiveness include (Farabee et al., 1999):

- Client identification, assessment, and referral;
- Recruitment and training of treatment staff;
- Redeployment of correctional staff;
- Overreliance on institutional versus therapeutic sanctions;
- Lack of aftercare; and,
- Coercion.

These identified barriers, along with the complexities involved with delivering evidence-based services to offender populations, underscore the need for a taking a systems approach to the management of substance-involved offenders.

How Does Delaware Measure Up to These Benchmarks?

While the purpose of this report is to examine processes related to offender treatment, a number of findings contained in this and previous reports provide indicators regarding Delaware's performance in relation to the aforementioned principles for effective correctional substance abuse treatment.

In terms of **screening and assessment**, Delaware conducts standardized clinical assessments (primarily using the ASI) on offenders in both community and institutional treatment settings. However, as shown in the judges' survey in Section IV, assessment information is not generally available to coincide with sentencing decisions, and is used later in the process primarily to weed out offenders who are grossly inappropriate rather than making decisions to differentiate offenders among various supervision and treatment options. Clinical assessments are required before offenders can be authorized for community-based treatment, but these assessments



may not occur in time to facilitate rapid entry into programming. Some assessments are conducted on offenders at an early stage of processing (for example, in the 6 for 1 program for detainees at Howard Young Correctional Institution described in the previous section), but this information is not routinely used for sentencing purposes, nor is it available in a database for future judicial, treatment or research purposes.

Likewise, assessment information does not appear to be used consistently to develop **comprehensive treatment plans** based on the characteristics of the offenders. In many instances, offenders are processed through the assigned programs with little differentiation in treatment or supervision strategies based on their needs. Opportunities for more effective and differentiated treatment planning are being provided by the current experiments in drug court (assigning participants to different tracks based on their risk and need characteristics) and by the Serious and Violent Offender Initiative, where case managers develop comprehensive reentry plans before offenders are released from prison, update those plans on a regular basis, and offer a wider range of supervision and treatment options.

Delaware has established a variety of programs in the institutions and in the community that provide **long term and intensive substance abuse treatment services**. The KEY and Greentree programs are designed to be approximately six to 18 months in length, and CREST is designed to provide six months of primary or transitional treatment. The penetration rate (the proportion of offenders who can access treatment, especially in the institutions) is unmatched by any other state. In addition, the Fresh Start Program described in Section II is designed to be approximately six months in length, and the Gateway program (also described in Section II) is designed around a 90-day model. Non-residential services, however, lack depth in terms of length and intensity, with the exception of programming for those with co-occurring substance abuse and treatment disorders and the new DSAMH day treatment programs. As described in Section IV, judges indicated a need for more community-based programs, along with more choice in terms of program approach. In addition, more intensive residential and outpatient services in the community would likely reduce the number of people who violate probation while they are waiting for admission to residential programs, and reduce waiting lists overall.

Delaware has established a wide **range of supervision options** for offenders, and treatment is available to serve offenders in all supervision levels. Judges, however, perceive that treatment can be accessed more reliably at higher supervision levels.

Delaware has also established a **continuum of care** through the KEY/CREST/aftercare program, and has TASC case management available to encourage participation through the continuum. However, a preliminary examination of outcomes presented in *Sentencing Trends and Correctional Treatment in Delaware* (April, 2002) showed that while inmates who participated in the planned KEY/CREST/aftercare continuum had the best outcomes in terms of felony recidivism, only about 20 percent of the 1999 snapshot CREST population had flowed down from a KEY program. The flow of offenders between correctional and community-based programs that would support unbroken, continuous treatment, is unknown.



Data related to substance-involved offenders in treatment resides in several databases. The courts, DOC, DeISAC, and DSAMH all maintain data related to sentencing, supervision, or treatment, and some data is maintained by contracted service providers. In addition, TASC and drug court information also appears in the Drug Court Information System (DCIS) in the Superior Court. However, a **management information system for tracking and managing offender treatment** that contains centralized information as described above does not exist in Delaware. Tracking court-ordered offenders to treatment admission required cobbling information together from a variety of sources. Information from assessments that describes the needs of substance-involved offenders is not maintained in any justice system database, and the information that is maintained by DSAMH is not shared routinely with the justice system. (While client-specific assessment information is confidential and protected under CFR 42, client data can be shared for research purposes.)

The KEY and CREST programs have undergone rigorous **performance evaluations** by the University of Delaware during their earlier stages of development, and more recently, a comparative analysis of outcomes of KEY, CREST, and Greentree was reported in *Sentencing Trends and Correctional Treatment in Delaware*. Additional information related to this programming will be collected as part of an ongoing national study referred to as CJDATS, in which both the University of Delaware and the Statistical Analysis Center are participating. However, KEY and CREST have not been as well studied since the expansion to a system-wide application, and most other programs have not been evaluated at all.

While reviewing materials for this report, Committee members reviewed a 1992 Delaware report entitled *Effective Management of Drug Involved Offenders* developed by the Drug Involved Offender Coordination Committee. The committee was established by then Governor Michael N. Castle as a joint committee of the Criminal Justice Council and the Lieutenant Governor's Drug Abuse Coordinating Council. Chaired by Judge Richard S. Gebelein, the committee called for an expansion of substance abuse treatment services, the creation of TASC, and made several recommendations to improve coordination of these services with the justice system. Since that time, treatment capacity for offenders has been expanded significantly with the addition and expansion of KEY and CREST. TASC has become operational and has expanded to provide evaluation and case management services. However, issues related to policy and inter-system communication and coordination, including data management, have not yet been resolved satisfactorily. This report is included as Appendix A, as its findings, conclusions and recommendations are still relevant almost fifteen years later.



Section III: Placing Delaware Offenders in Treatment

One of the stated objectives of the Delaware Sentencing Research and Evaluation Committee's research plan is to conduct a process study of residential treatment practices to answer the following questions:

- What are the residential treatment practices?
- Do people actually get into the programs that are ordered?
- How long do they wait?
- How many never get there?
- What is the effect of addiction sentences?
- How does that affect sentencing practices?

To begin to answer these questions, a sample of offenders convicted in the Superior Court and sentenced to participate in residential treatment was drawn, and cases were followed through to treatment admission until the end of the study period. In addition, descriptive information about the process of referring and placing court-ordered offenders into residential treatment was gathered.

It is important to note that the study focused only on the process of placing offenders into *residential* treatment. As such, only cases ordered to Level IV or Level V with a condition to residential treatment were examined. Large numbers of offenders are ordered to be evaluated for treatment, or are ordered to non-residential programs. A recent examination by the Department of Correction found that in January 2004, 2879 of 5300 Level II offenders had a court order for treatment evaluation and/or placement. Therefore, findings from this study should not be translated to include the offender population as a whole that is ordered to treatment or that needs treatment.

To understand the findings of this study, it is important to understand the context within which offenders are sentenced to treatment.

System Overview

The attention that the courts pay to treatment issues, reflected in their sentencing practices as well as their interest in treatment policy, represents a fundamental shift from sentencing practices that were prevalent through the mid-1990s. As treatment capacity for offenders expanded, sentencing policy changed. This philosophical and practical shift to the imposition of treatment sentences is perhaps the most significant change in justice policy since the implementation of sentencing guidelines in 1987 and Truth in Sentencing in 1990.

Under SENTAC, punishment and treatment are coexisting goals. Judges are called upon to attempt to find community-based sanctions and reserve incarceration for violent and recalcitrant offenders. As such, judges need to be able to impose restrictions and conditions that ensure public safety. As treatment in Delaware became viable and services began to expand, the courts adapted by incorporating



conditions for treatment into criminal sentencing. This adaptation allows the judiciary to balance the need for punishment as outlined in sentencing guidelines with the need for treatment on an individualized basis.

A large proportion of sentencing orders contain some sort of condition for treatment, and those orders are structured in a variety of ways. Many of the treatment sentences imposed are “addiction sentences,” whereby a portion of the Level V or Level IV sentence may be suspended upon successful completion of treatment.

In some instances, a specific length of time at a particular level of supervision is imposed, with the condition that the offender participate in treatment during this period of supervision. The sentence is not suspended upon treatment completion.

Some sentencing orders are structured that make participation in a *particular* program a requirement, while others may only specify “residential treatment” or “treatment to be determined” by DOC or TASC. Other sentencing orders contain requirements for the offender to receive an assessment with a further recommendation to be submitted to the court once the assessment is completed.

Most sentencing orders with a condition for community-based residential treatment include Level IV supervision, since by practice, residential treatment is considered Level IV. If treatment is not immediately available (and even when there are no waiting lists, administrative procedures generally take at least a few days), judges may order the offender to be held at Level V or at another supervision level (generally Level III) until treatment placement.

One of the major difficulties in interpreting sentencing orders related to treatment participation is that many orders are imposed when offenders are already serving existing sentences, when defendants are under the jurisdiction of more than one judge or court, or when defendants are sentenced for multiple events within a short period of time. As an example, an offender may be sentenced to a Level IV residential treatment program, and before he or she is admitted, is sentenced to a Level V treatment program on a pending charge or probation violation. The new sentence to Level V negates (or at least defers) the Level IV sentence.

In addition, many sentences imposed, particularly for violations of probation, contain language that reimposes all other conditions of the previous sentence. It can be difficult to ferret out these pre-existing imposed conditions. In some cases, sentences are modified, and the modifications do not always get into the computerized systems. Sometimes what judges order does not translate well through information systems and to DOC recipients, and the orders are misinterpreted.

Although most sentencing orders from Superior Court appear to be straightforward on their face, some factors may contribute to a lack of clarity regarding the judges’ intent, or may cause confusion when calculating time to be served. There is considerable lack of uniformity regarding program names. For instance, KEY may be referred to in general, or a site-specific KEY program may be ordered. In addition, short-term or long-term KEY may be ordered. Some judges may order KEY or



CREST “Relapse Prevention” or “Tune-Up.” Some court orders are specific to the treatment program required, while others refer to general residential or outpatient treatment.

In addition to court-ordered referrals, offenders can be referred to treatment by probation officers, correctional counselors through classification, or other justice professionals (e.g., public defenders). They can also “self-refer” or otherwise volunteer for treatment. These other referral types compete for admission with court-ordered offenders.

All offenders who participate in KEY or Greentree must be sentenced to Level V. Level V offenders are evaluated⁴, given a security classification, and assigned to programs by the DOC’s Classification Department. According to the DOC, in general, court-ordered offenders receive priority for treatment in institutional programs (over those who are classified to by DOC or who otherwise volunteer), although there is no official policy giving court-ordered offenders such priority. Placement in the KEY or Greentree programs is then made on a first-come, first-served basis depending on bed availability. Offenders with open charges, who are grossly inappropriate for treatment, or who present a security risk are not admitted to Level V treatment programs despite a court order. In these cases, the Classification Department attempts to notify the judge regarding the problem.

To be admitted to CREST programs, offenders must be sentenced to Level IV; Level V with a “flowdown” order for Level IV treatment; or Level V with eligibility for community placement (for instance during the last six months of their sentence). They must also be eligible for placement in a work release center, although currently, some offenders otherwise eligible for CREST are prohibited from work release by law or policy⁵. Most CREST clients are court-ordered, but the Department of Correction may also classify Level IV offenders to CREST. The length remaining on the sentence is also a factor in CREST placement. The Department of Correction tries to place people in CREST who have enough time left on their sentences to finish the program. Priority for placement is given to offenders sentenced directly to Level IV treatment, and to Level V KEY graduates who have Level IV to follow.

Very few offenders receive a clinical drug and alcohol assessment prior to admission to the KEY, Greentree or CREST programs. During the first thirty days after admission to KEY or CREST, an assessment is conducted using the Addiction Severity Index and other instruments. Offenders ordered to or requesting Greentree placement are interviewed by counseling staff prior to admission, and are assessed during the first few weeks of their stay. All programs attempt to notify the sentencing court or other referral agent if the offender is deemed inappropriate for or refuses treatment.

⁴ They *do not* receive a clinical assessment.

⁵ Work Release admission policies are contained in the SENTAC Truth in Sentencing Benchbook (SENTAC, 2003).



Offenders can also access community-based residential treatment programs operated by contract through the Division of Substance Abuse and Mental Health (DSAMH). While these programs admit offenders, they are not designed specifically for offenders.

To be admitted to state-funded community based residential (as well as outpatient) treatment programs, prior authorization must be obtained from the DSAMH Eligibility and Enrollment Unit. An assessment must be conducted by an authorized agent of DSAMH (e.g., TASC, treatment providers) and forwarded to the Eligibility and Enrollment Unit that authorizes length and intensity of treatment. If the offender is not a TASC client, there is no system to provide continuous coordination between the criminal justice system and DSAMH processes, especially if the offender changes criminal justice status (e.g. moves from pretrial to sentenced status). In addition, there is usually a waiting list for residential treatment. According to DSAMH, length of wait varies but may be as long as two months at times of peak referrals.

Assessment results are used to make placement recommendations to the justice system if the case has been assigned to TASC. However, these results are not usually available to coincide with sentencing (although they are more available for probation violation or drug court hearings). Unless the person is in drug court or in another special category (e.g. reentry court), the results are not shared routinely with the justice system. As such, it is possible for offenders to be assessed multiple times. Other offenders wait for assessment after they are sentenced to residential treatment. In addition, a database that would enable a review of offender substance abuse treatment and other needs is not available to justice system researchers or other justice professionals.

Tracking Study Overview and Methods

To determine the effectiveness of the procedures for admitting court-ordered offenders to residential treatment, a sample was derived from Superior Court sentencing orders and tracked through treatment admission. The study sample was obtained by identifying sentencing orders for offenders who were sentenced in Superior Court during November and December 2001 with a condition for participation in residential treatment. The cases were then tracked to examine whether the offender was placed in the treatment program that was ordered, how long it took for treatment admission, and whether or not an alternative treatment placement was arranged. The study period ended in February 2003.

Due to different methods of entering sentence data and different language used by judges, it was difficult to clearly identify sentences that impose treatment conditions. To get the sample, standard sentence order databases were searched for specific terms and phrases related to treatment. A manageable sample, designed to be representative of all three counties, was randomly selected from the electronic sentence order system, and paper sentence orders were located for review and verification. The sample was further refined by excluding those orders that called for only bootcamp or VOP Center (without treatment); that called for only a treatment evaluation or aftercare; or sentence modifications that continued or suspended an



existing treatment sentence or condition. These exclusions left a sample of 153 cases that were then tracked through the system.

A number of methods were used to determine if court-ordered treatment was obtained. Spectrum Behavioral Health Services, the contractor that previously provided KEY/CREST correctional treatment services, supplied admission dates for offenders ordered specifically to their programs. Kay Sturtz and other administrators of the Greentree program provided information related to Greentree admissions. Gerry Gregg, from the Department of Correction, provided information about offenders who were placed in community-based correctional treatment programs, and had information about other offenders as well. Anthony Rendina, Department of Correction, supplied information about offenders who could not be located through provider records. Alan Grinstead provided information about offenders who were serving probation sentences, and Chris McKinney provided information about some offenders who participated in the CREST Program at the Plummer Work Release Center, or who otherwise were at the Plummer Center during the study period.

There is no centralized place to access accurate information about offender participation in treatment. Much of the tracking involved cobbling together information from a variety of sources. For example, when an offender was found who had been transferred from a major institution to Morris Correctional Center (a Level IV work release facility that provides CREST treatment), researchers suspected that the person may have been admitted to CREST and would follow up with program providers to verify that the offender had, in fact, entered the program.

Some information supplied by providers was incorrect. Providers failed to identify some people who had been admitted. In some cases, treatment provider data were inconsistent with DOC and sentencing order data.

Because of crosschecking databases and other methods to verify records, researchers are relatively confident in the data, but it was very time-consuming to produce. In addition, only admission information was sought. Discharge and outcome information is likely even more elusive.

Results

The court ordered a variety of programs, with the majority of cases ordered to KEY or CREST. Most orders specifically named a program, while others called for generic inpatient or residential treatment. Some orders recommended programming as determined by the Department of Correction or TASC.

Table 1, *Programs Ordered*, shows the programs that judges ordered as a condition of a sentence in rank order.

**Table 1. Programs Ordered**

Program	Number	Percentage
KEY	66	42%
CREST (direct sentences)	53	35%
Inpatient Drug/Residential (not specific to program)	14	9%
Recovery Center	8	5%
Greentree	4	2%
To be Determined by DOC	3	2%
To be Determined by TASC	3	2%
Reflections	1	.05%
New Way By the Sea ⁶	1	.05%

The programs ordered include only the initial treatment condition. For example, some KEY conditions may have included participation in CREST upon successful completion, but these additional placements were not tracked.

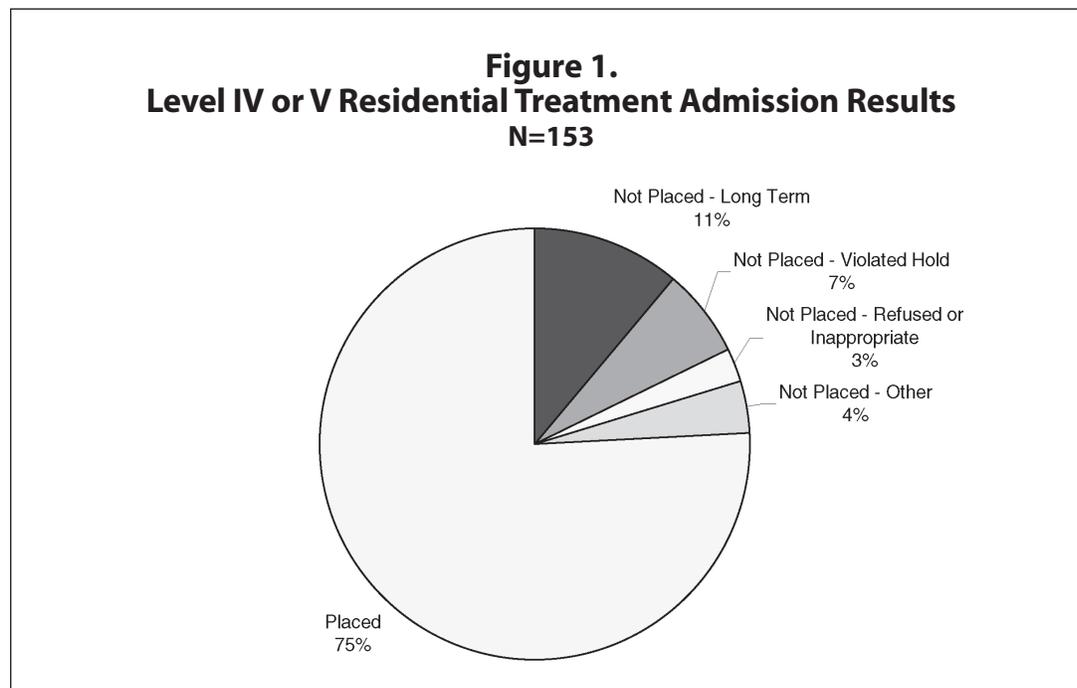
Overall Admission Rates

Of the 153 cases examined, a total of 116, or 75.8 percent, were admitted to the court-ordered program, or an alternative program, within the study period.

Operating and accessing treatment services inside a sentencing and correctional framework presents a number of challenges. As depicted in Figure 1, *Level IV or V Residential Admission Results*, 17 cases (11.1 percent) were not admitted because they were serving long-term sentences. This group may eventually be admitted to treatment. Admissions to KEY are designed to fall within the last 12-18 months of an offender's sentence, so graduation is tied to release to the community, preferably to a CREST program. Thus, placement may be delayed to coordinate with anticipated release dates.

An additional 20 cases (13.0 percent) were not admitted to treatment under the current sentencing order. As Figure 1 shows, they were not admitted because they violated probation before treatment admission, they refused, were deemed inappropriate for treatment, or they were not placed for other reasons. These cases are discussed in more detail later in this section.

⁶ This program is no longer in existence.



Time to Admission

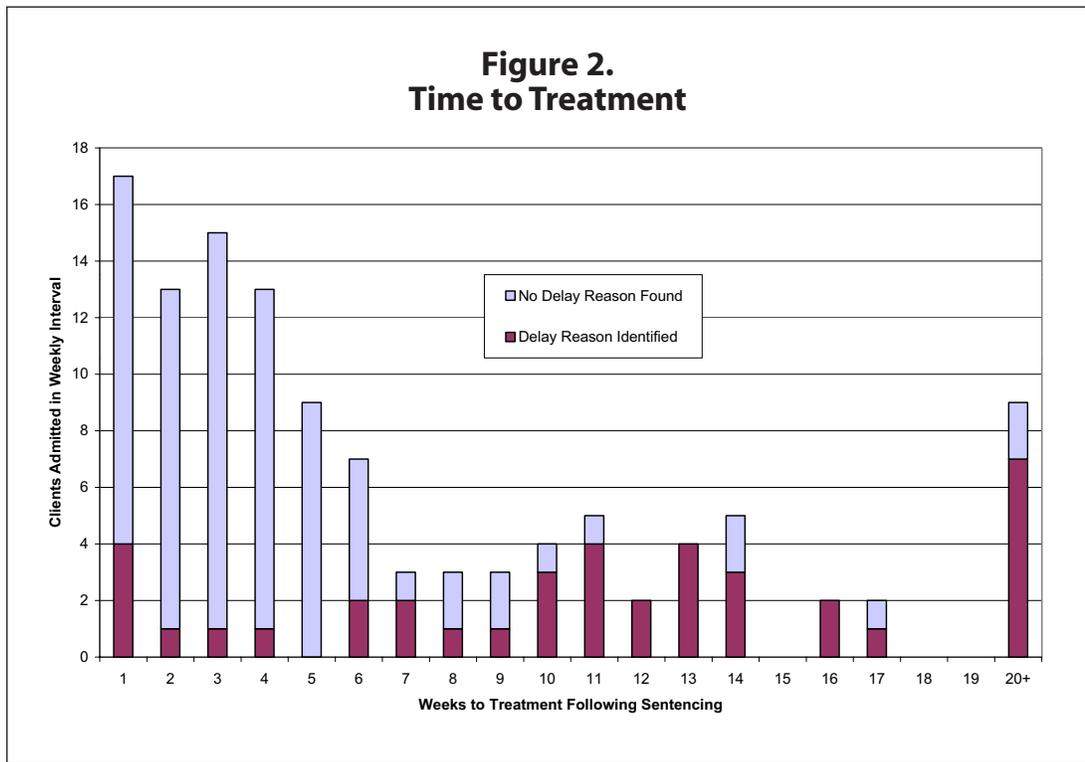
Figure 2, *Time to Treatment*, shows the time to admission of all those offenders placed in Level IV or V treatment during the study period (N = 116). Seventeen people (14.7 percent) were placed within one week; 25.8 percent within two weeks; and 50 percent were admitted within 28 days. It took longer than a month for half the admitted sample to be placed, with 49 cases (42.2 percent) waiting from five to 17 weeks for admission. Nine cases (7.8 percent of the sample) took 20 weeks or more to be admitted.

Many individuals who were placed into treatment after 28 days had identified factors that may have contributed to the delay. These factors include having pending charges, serving a prior sentence that may be lengthy, receiving a current sentence that may contain lengthy jail or prison time, or having identified mental health issues that may result in placement delay.

DOC Institutional Programs

Fifty-four out of 116 individuals (46.6 percent) were admitted to treatment programming at a Level V institution. Fifty individuals were admitted to a KEY program and four to Greentree. Thirty-three percent of the offenders in this category were admitted within 28 days.

Pending charges could have contributed to placement delays in 16 cases. By DOC policy, pending charges need to be resolved before program admission. Other delays resulted from serving time on previous sentences (2 cases), lengthy current sentence (6 cases), or mental health issues (1 case). Researchers were unable to determine a cause for delayed admission in six additional cases.



DOC Non-Institutional Programs

Forty-eight individuals (41 percent) were admitted to a DOC non-institutional treatment program (CREST). Seventy-seven percent of admissions were admitted within 28 days. Delays in admission resulted from pending charges or from other reasons that could not be determined.

Community-Based Programs

Fourteen individuals (12 percent) were admitted to non-correctional community-based treatment programs, including Connections, the Delaware Psychiatric Center, Recovery Center of Delaware (RCD), Psychotherapeutic Services, Inc. (PSI), Reflections, the VA Hospital, and Sojourners Place. Forty-three percent of individuals in this category were admitted within 28 days.

Delays in placement could be attributed to pending charges (2 cases), serving time on prior sentences (1 case), and mental health issues (1 case). In addition, a number of orders in this category were modified to allow for admission to Sojourners, the Veteran’s Administration Hospital, or Psychotherapeutic Services, Inc. (PSI). Other orders indicated that placement decisions were to be determined after a TASC evaluation. It is possible that cases that are more complex or need more specialized services end up in community-based non-correctional treatment, and these complexities likely account for some of the admission delays.

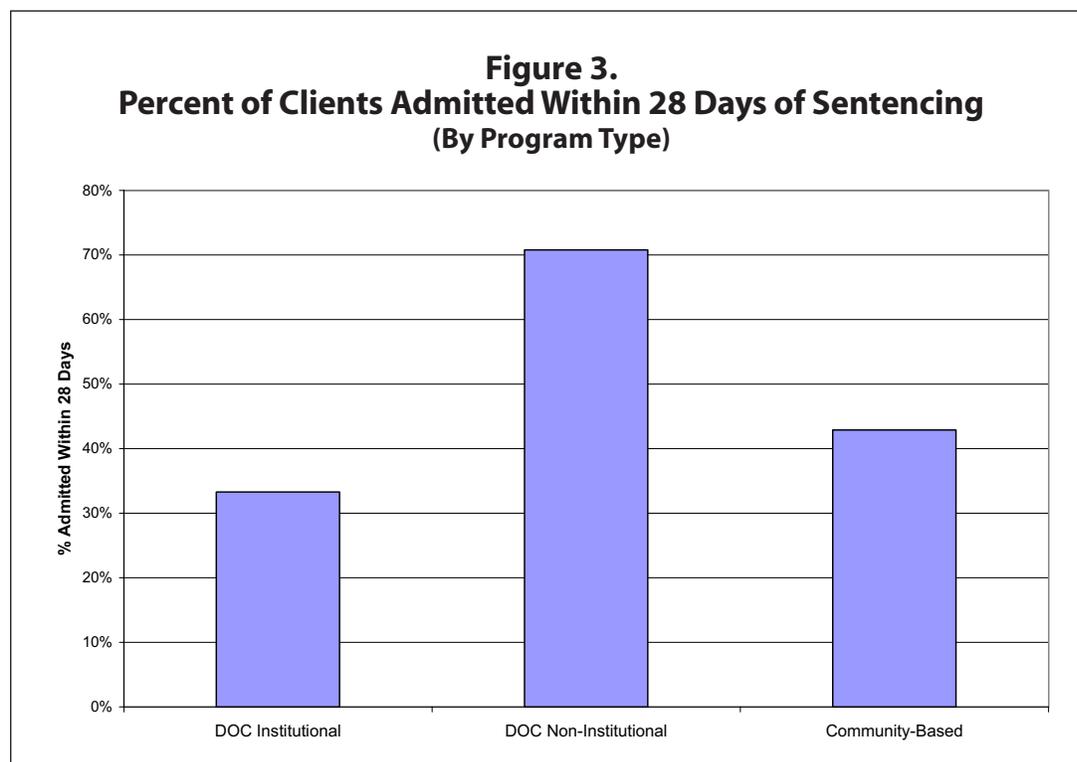


Figure 3, *Percent of Clients Admitted Within 28 Days of Sentencing*, compares the percentages of offenders who were placed within 28 days among the three treatment categories. Offenders are admitted to CREST the most quickly, followed by community-based programs and Level V programs (KEY and Greentree).

TASC

TASC staff provides assessment, referral and case management services statewide for offenders coming through Delaware's Superior Court and Court of Common Pleas drug courts. In addition, TASC administers a statewide drug diversion program for non-violent offenders coming through both the Superior Court and Court of Common Pleas. This program includes regular court appearances, drug testing, and substance abuse education and treatment.

A large proportion of the sample was ordered to TASC case management. A condition for TASC participation was not always noted in the sentencing order, but docket entries were reviewed and other records searched to identify a condition for TASC. One of the difficulties with tracking this population is that many violations impose the same conditions as in the original order and these conditions were not apparent in the Violation of Probation order or sentence modifications reviewed, and sometimes are not available in the electronic system at all.

Of the 116 offenders placed in treatment, forty-five (39 percent) appeared to have TASC as a condition. 41.7 percent of cases identified as TASC cases were admitted within 28 days, compared with 50 percent of non-TASC cases placed within 28 days.



Of the cases identified as TASC, 20 were placed in DOC Institutional Programs, 15 were placed in DOC Non-Institutional programs (CREST), and 10 were placed in Community-based Programs.

While this analysis shows an intersect between treatment sentencing orders and TASC, it was not designed to assess the effectiveness of TASC. In addition, it is likely that more complex cases are assigned to TASC. Therefore, major conclusions about TASC should not be drawn from this analysis. Rather, results should be used to inform future studies.

“Hold At” Sentences

It has been policy in Delaware since the inception of SENTAC for judges to order offenders to a particular level, with the stipulation that they be temporarily held at another level until supervision or programming at the ordered level becomes available. It is quite common for offenders who are ordered to Level IV treatment to be ordered to wait at Level V or Level III until they can be placed.

In the sample of 153, 21 individuals (13.7 percent) were sentenced to Level IV residential treatment with a stipulation that they be held at Level III while awaiting treatment admission. Of these, eight of the 21 (38 percent) were successfully admitted to treatment. Nine individuals in this category (42.8 percent) violated their probation before treatment admission. Most of these violators ended up in Level V treatment or in Level IV CREST programs. Three sentences were modified before treatment admission, and one case contained no DOC record of the individual ever serving his ordered sentence.

A large proportion of individuals waiting for residential treatment violate their sentences before they are placed. While guidelines are structured to recommend punishments based on the crime and criminal history of the offender, most offenders who need residential treatment are likely to be actively using substances and are at high risk for violating their probations by failing to report, testing positive for drugs, or committing new crimes.

Offenders Not Admitted to Court-Ordered Treatment

Of the 37 offenders who were not admitted to their court-ordered treatment during the study period, seventeen may yet be admitted as they continue to serve their long-term sentences. The remaining 20 cases (13 percent of the total) were not admitted to their court-ordered treatment, and it is unlikely or impossible that they will enter treatment under the sentencing orders drawn for this study. In most cases, actions on the part of the court or the defendant resulted in their not being admitted to treatment. A number of reasons were identified to account for these cases not being admitted and they are presented in Table 2, *Persons Not Admitted to Court-Ordered Treatment*.

**Table 2: Persons Not Admitted to Court-Ordered Treatment**

Reason person was not admitted	Number of cases
Violated before being admitted*	10
Refused treatment	2
Inappropriate Clinical	1
Inappropriate Maximum Security	1
Modified sentence	1
Incarcerated due to pending charges	1
Released to other authorities	1
Died	1
Assigned as inmate worker	1
No records found on individual	1
* Nine were waiting for admission at Level III; one was being held at Level IV.	

Discussion

Given the relatively informal mechanisms for placing court-ordered offenders in treatment, including the lack of electronic record keeping and communication, the system overall appears to be working in many cases. Of the 75 percent that were placed, half of the subjects (38 percent overall) were admitted to the court-ordered program, or an alternative program, within 28 days, and were determined to be appropriate for the program. In addition, a reason was identified that contributed to placement delay or the placement not occurring at all in almost all cases.

However, it is important to remember that when these findings are translated to the system as a whole, there are large numbers of people who are in a transitional state waiting for residential treatment admission. To make annual estimates, the results reported herein based on two months of Superior Court sentencing orders would need to be multiplied by at least 6. Thus, at least 50-60 offenders sentenced to treatment in a year could potentially violate before they are admitted to their program. While the numbers of people waiting for treatment are not available in any central location, on October 8, 2003, a DOC waiting list revealed that 15 people were waiting at Level V for admission to residential treatment at the Recovery Center of Delaware.

Although the Division of Substance Abuse and Mental Health (DSAMH) maintains assessment protocols for those entering community-based programs and offenders who enter KEY or CREST programs receive assessments during intake, judges often



do not have adequate information to make well-informed decisions about treatment placement, and often do not have adequate information about offenders' current status. Unless they are currently in treatment or active with TASC, most offenders do not receive a clinical assessment (or even a substance abuse screening) prior to sentencing, and judges rarely have information regarding an offender's specific treatment needs. Despite the lack of clinical information available to the judges, very few individuals were rejected by program providers as inappropriate for treatment, and only a small number of individuals refused treatment. Given the numbers of offenders who need substance abuse treatment, judges who order treatment are likely to be correct in their identification of need. However, the high acceptance rate is likely reflective of the fact that most programs are not very discriminating about who they will admit. Placing people in programs for which they are not suited presents operational challenges and leads to poor outcomes.

About half of court-ordered offenders are placed in treatment relatively quickly – within 28 days. However, many of those waiting for residential treatment in the community violate their probations before admission. Quicker admissions could possibly reduce the rate of pre-treatment violations. Policy related to holding people at alternative supervision levels while waiting for treatment should be examined in light of this finding.

A major tenet of drug courts is to place people into treatment as soon after arrest as possible, to capitalize on the “trauma of arrest” and to make the most of the motivational opportunities that contact with the justice system may provide. This principle is important for all offenders, and 28 days may be not be an adequate standard in terms of placement time.

Delaware's system for placing court-ordered offenders into treatment is very informal. It works as well as it does because people in the system are dedicated to providing treatment for offenders, and because court orders receive a high priority by the DOC. There are a variety of mechanisms for program admission, multiple agencies that must coordinate, and a variety of people and agencies responsible for moving offenders into treatment (e.g., TASC, DOC Classification). This occurs, for the most part, in the absence of formal policies or procedures.

Different styles of sentencing and conflicting sentences are common, and there is no standardized process for reconciling these conflicts. In addition, there are competing paths to admission, including DOC Classification, court orders, self-referrals, and referrals by others in the justice system. Judges' orders may not align well with availability of beds. This is frustrating for judges who may find out about delays through communication from inmates who have not been placed.

Although many reasons for admission delay appear logical, they result in large part from a lack of information as offenders are being processed through the criminal justice system. Many of the factors that contribute to delays in admissions result because sentencing judges do not routinely have access to all current case

information. Delays result and confusion develops when judges are unaware of sentences imposed by other judges or courts, when open charges are present, and when offenders are sentenced in rapid succession for separate events.



The system basically relies on paper and informal communication. Computer systems between the Courts and the Department of Correction are not well linked, and there is widespread opportunity for communication errors and for cases to slip through the cracks. Tracking offenders through these systems required a lot of legwork to compare information among several agencies and courts. There is no single place where offender sentencing orders, assessment results, treatment referrals, admissions, current status, and discharge information is available.

This study focused only on offenders who were ordered to Level IV or V with a condition of residential treatment. Current data systems would not support tracking offenders into other levels of care. For example, there is currently no way to determine how many Level II or III offenders receive their court-ordered treatment, nor to determine how many were evaluated for substance abuse, even when court-ordered.



Section IV: Survey of the Judiciary on Adult Offender Treatment Services

In April 2003 the SENTAC Research and Evaluation Committee distributed surveys to judges in Family Court, Superior Court and the Court of Common Pleas. The survey was designed to assess judges' practices, attitudes and opinions regarding treatment for adult offenders in Delaware.

Because major policy issues had been raised by the Committee's previous report, *Sentencing Trends and Correctional Treatment in Delaware*, including the sheer number of sentences that were imposed with a condition for treatment, the Committee decided it was important to get a sense of how judges might respond to changes in the treatment system, as well as how the judges might like to see the system improve. A full copy of the survey form is included as Appendix B.

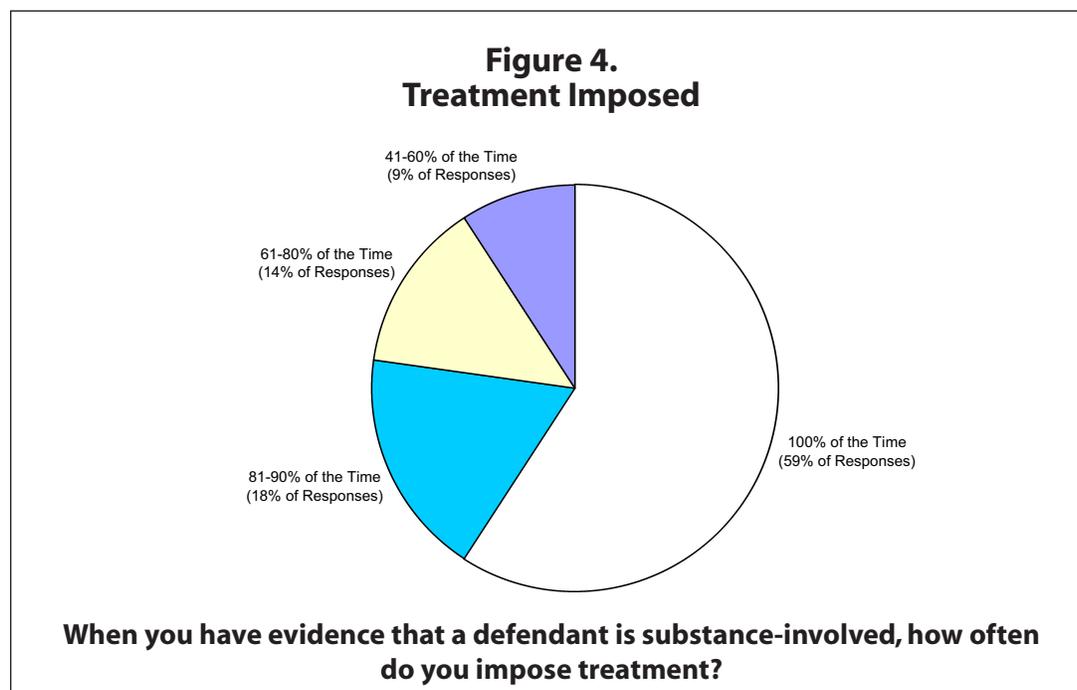
The survey revealed that judges' sentencing practices are influenced by the availability of treatment, and that judges' sentencing practices would likely change if treatment availability changed. Judges called for more residential services in the community, and indicated that they would sentence fewer people to Level V if effective community-based residential services were more available. Judges indicated they have a high propensity to order treatment when they believe an offender is substance involved, but the information they need to make these determinations is largely unavailable at sentencing.

Results

The following section presents responses that judges and commissioners had to specific questions in the survey. Charts are accompanied by text that highlights the key points raised by the responses, and when applicable, selected comments made by judges are presented.

The response rate to the survey was 53%. All judges who responded from the Court of Common Pleas and the Superior Court indicated they sentence people to treatment at Levels IV and V, with the exception of one Superior Court judge who was new and did not yet carry a criminal caseload. No Family Court judges reported they sentence adult offenders to treatment at Levels IV and V, but several Family Court Commissioners (six out of seven who responded to the survey) indicated they do sentence adults to treatment in Levels IV and V. Additional information about survey methods and limitations, along with a list of data improvement recommendations, is included as Appendix C.

About 45 percent of the judges who responded indicated that when sentencing offenders to treatment, they usually designate a specific program (such as KEY, Greentree, etc.). When asked to rank programs in order of their usage, judges indicated they order people to CREST most frequently, followed by KEY, Greentree, and the Recovery Center of Delaware. The ranking of outpatient programs (Brandywine, SODAT, Kent County Counseling, Thresholds, NET, Open Door and other) varied based on each judge's county of jurisdiction, with many judges indicating that while they were



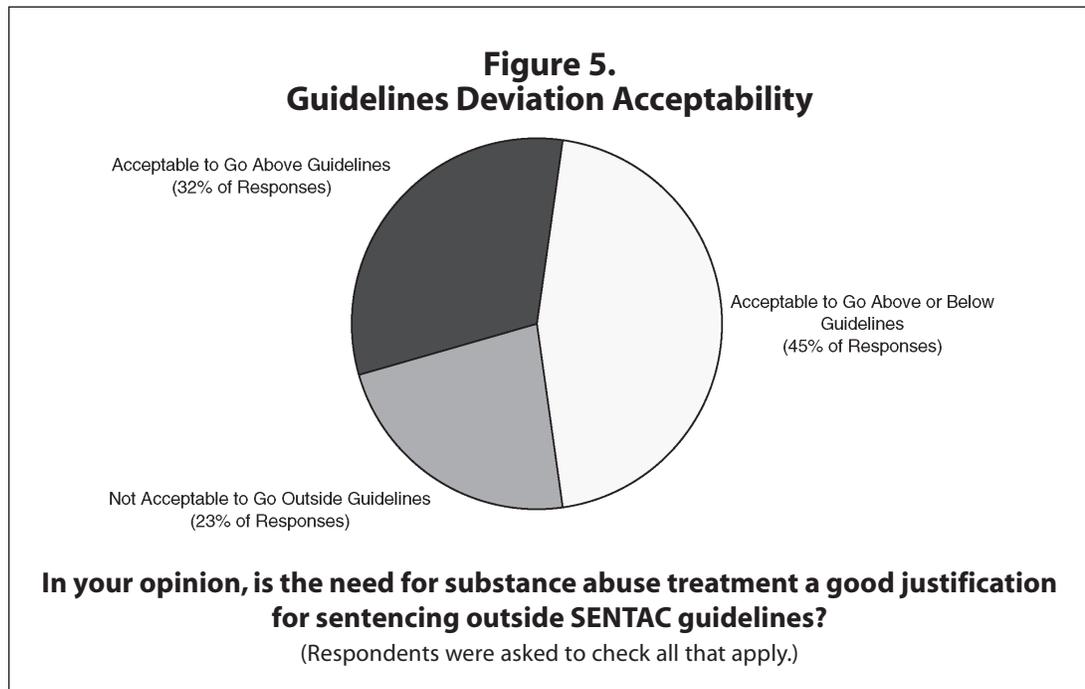
specific about residential programming, they usually do not specify a particular program when sentencing offenders with a condition for outpatient treatment.

Several questions in the survey related to caseload size. For instance, judges were asked, “About how many offenders have you sentenced during 2002 with any condition for substance-abuse treatment participation?” Survey designers were aware that judges do not generally have access to their own sentencing data, and expected responses to be estimated. Many judges indicated discomfort in answering these questions, declined to answer, or indicated they did not know the answer or were just estimating. These questions were designed to measure perception, and responses cannot be used as an indication of actual volume and are thus not included in the analysis.

When comparing judges’ responses to caseload size questions to actual numbers of sentences imposed, judges overestimated the number of sentences they impose that contain conditions for treatment participation. Therefore, judges believe that high proportions of their cases involve defendants with substance abuse problems, and that high proportions of defendants on their caseloads are ordered to treatment. Judges’ experience tells them that substance abuse in the offender population is an issue that concerns a large proportion of their caseloads and time, and this is, in fact, true.

As shown in Figure 4, *Treatment Imposed*, judges indicated they frequently impose treatment when they have evidence that a defendant is substance involved.

Fifty-nine percent of judges indicated they sentence to treatment all the time when they have evidence that a defendant is substance involved, and another 18 percent indicated they sentence to treatment between 81 and 90 percent of the time. Responses to this question indicate that judges believe it is very important to try to get offenders into substance abuse treatment when they have recognized substance abuse problems.



Judges are clearly interested in fashioning sentences to address the underlying substance abuse problems of defendants before them, and most are willing to go outside sentencing guidelines to accommodate the need for treatment. As shown in Figure 5, *Guidelines Deviation Acceptability*, most judges (77 percent) indicated they find it acceptable to go above the guidelines because of a defendant's need for substance abuse treatment. Of these, 45 percent believe it is acceptable to go either above or below the guidelines to obtain treatment for substance-involved defendants. Twenty-three percent of judges indicated they could generally fashion treatment to fit within the guidelines.

The policy impact of these attitudes on sentencing discretion for substance abusers deserves examination. When sentencing guidelines were developed, the emphasis on treatment was much less pronounced. These results show that in some cases the need for rehabilitation appears to supercede punishment called for in the guidelines, and that judges are willing to go above the guidelines to place people in treatment. Perhaps a review of the guidelines should be conducted to determine if guidelines specifically for treatment sentences should be developed.



Selected Comments

When asked about the rationale for their responses, judges who indicated they would go outside the guidelines because of need for treatment made the following statements:

“Because programs last longer than guidelines.”

“Sometimes the treatment needed is at a lower or higher level than SENTAC guidelines.”

“...Due to the delays in getting offenders into residential treatment programs, a sentence in excess of the guidelines may be called for to allow continued oversight by the court and correctional authorities while treatment continues.”

“...Severely addicted need control and treatment so need Level IV or V to protect safety of public....”

Judges who indicated that need for treatment is *not* a good justification for going outside the guidelines said that substance abuse treatment can usually be ordered within the guidelines, and if the sentence is too short then other options should be considered.

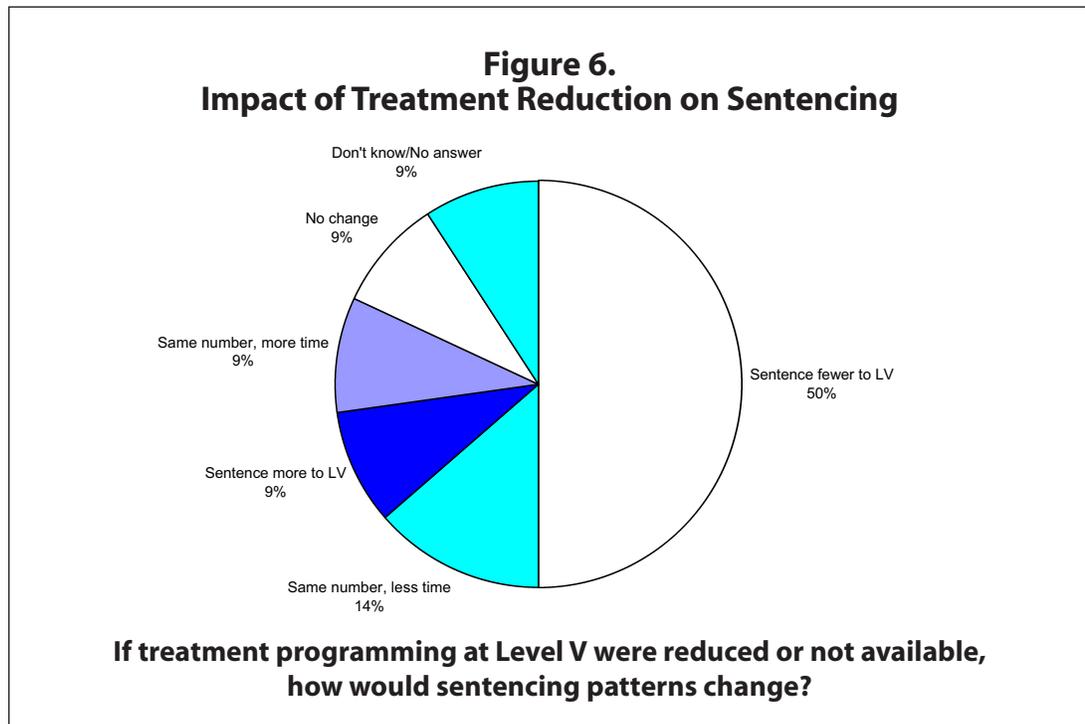


Figure 6, *Impact of Treatment Reduction on Sentencing*, shows that the majority of judges indicated they would sentence fewer defendants to Level V (50 percent), or would sentence the same number of people to Level V but for less time (14 percent) if treatment at Level V were reduced or eliminated.

Judges who indicated they would sentence **fewer people to Level V** generally justified their responses by concluding that Level V alone is not as effective for substance abusers, and that they are placing some people at Level V because the need for treatment justifies the punishment aspects of Level V.

Judges who indicated they would sentence **the same number of people to Level V but for shorter time** justified their responses by concluding that they impose Level V to allow for enough time to obtain the treatment. If treatment was unavailable at Level V, they indicated they would likely impose some jail time followed by community-based treatment.

Judges who indicated they would sentence **more people to Level V** said they would do so because they reserve Level V treatment for those who have previously failed, and would want to separate the defendant from drugs in the community.

Judges who indicated they would sentence **the same number of people to Level V but for longer time** said they would do so because they use Level V only for punishment, or because they would impose a definite sentence without the opportunity for early release based on program completion.



Selected Comments

Fewer to Level V

“Level V incarceration alone for substance involved defendants in need of treatment is less effective. I probably would opt for intensive probation with treatment.”

“If they can’t get the treatment they need at V then V time is not going to be effective.”

“If you build it they will come.....we send them where treatment is available.”

“Substance abusers need treatment and in the cases I see that fact outweighs the punishment/incarceration aspect, if there is any possibility of rehabilitation.”

Same to Level V, Less Time

“It is critically important to get people into treatment. I would probably tend to give people less Level V time so they could get treatment at Levels IV, III, or II.”

“....If no Level V treatment were available, an offender would be required to do some Level V time for failure to cooperate with probation. I probably would not require an offender to serve in Level V all suspended Level V time.”

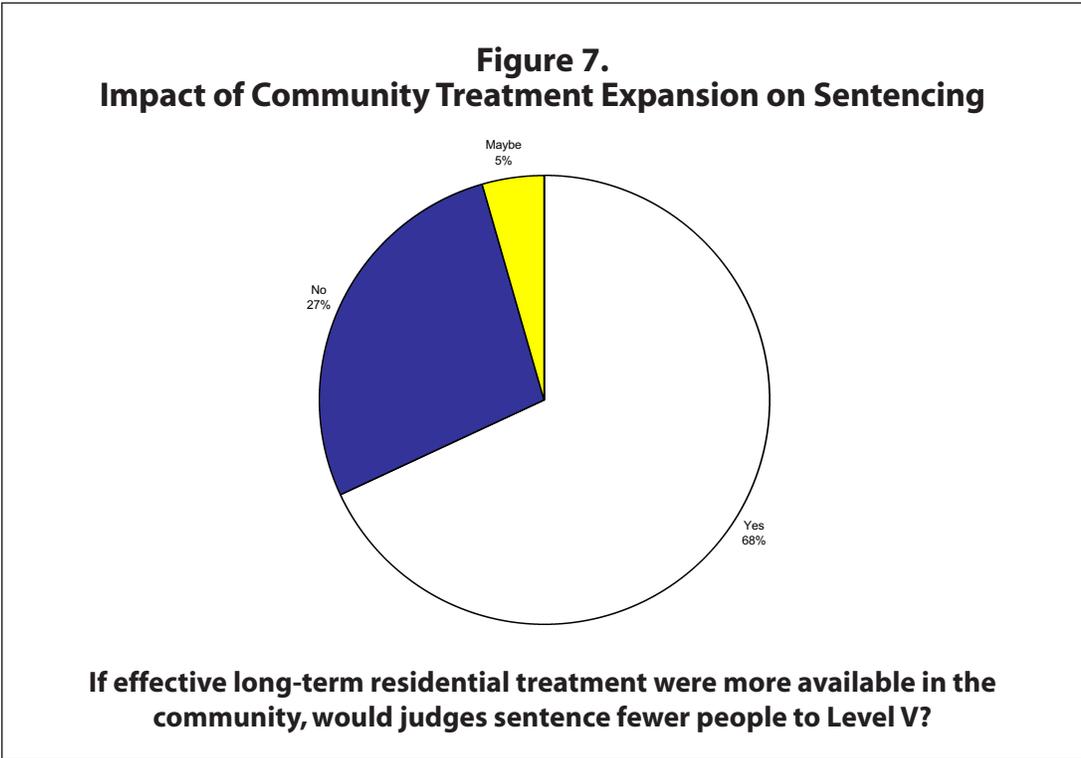
More to Level V

“Level V treatment is required for many who fail at community supervision. Without treatment, would likely impose longer sentence to keep defendant from drugs in the community.”

Same to Level V, More Time

“Treatment is available at levels other than V. V should be used as a punishment.”

“I use addiction sentences that end Level V upon completion of treatment. If no treatment, then would set number of years...”



The majority of judges (68 percent) indicated they would sentence fewer people to Level V if effective long-term residential treatment for offenders were more available in the community, as depicted in Figure 7, *Impact of Community Treatment Expansion on Sentencing*. Judges indicated they would use a credible community-based alternative if the offender did not present a risk to public safety.

Judges who indicated they would not send fewer people to Level V (27 percent) reasoned that they use lower levels of treatment first anyway, or that the defendants they send to Level V treatment need the structure of correctional confinement.

Selected Comments

<p><u>Fewer to Level V</u> <i>“Many defendants I see need residential treatment, but not necessarily incarceration.”</i></p> <p><i>“Initially I would do so to give offender a chance to succeed. If an offender failed to cooperate, then Level V treatment would be next.”</i></p> <p><i>“Key word is ‘effective.’”</i></p>	<p><u>Same or more to Level V</u> <i>“In-house treatment is better....long wait for bed space.”</i></p> <p><i>“I try not to sentence to incarceration based on Level V drug program. Why should I increase or decrease punishment for that reason?”</i></p> <p><i>“Probably not, because defendants usually need the structure of a setting of correctional confinement.”</i></p>
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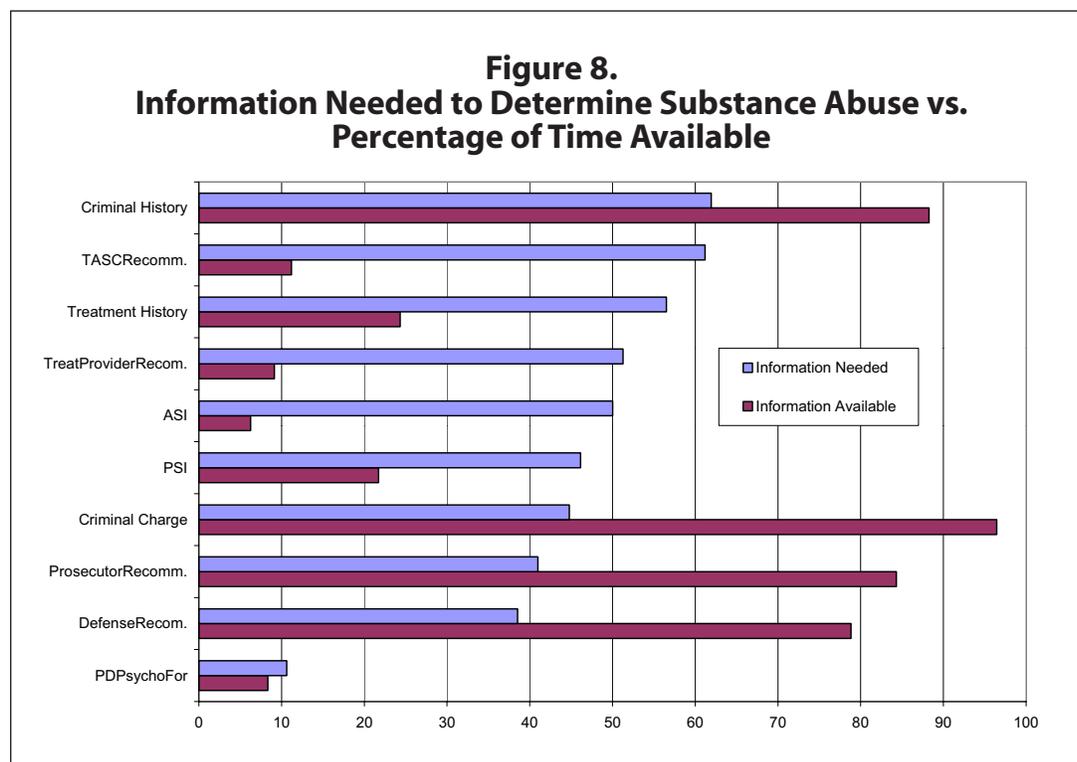
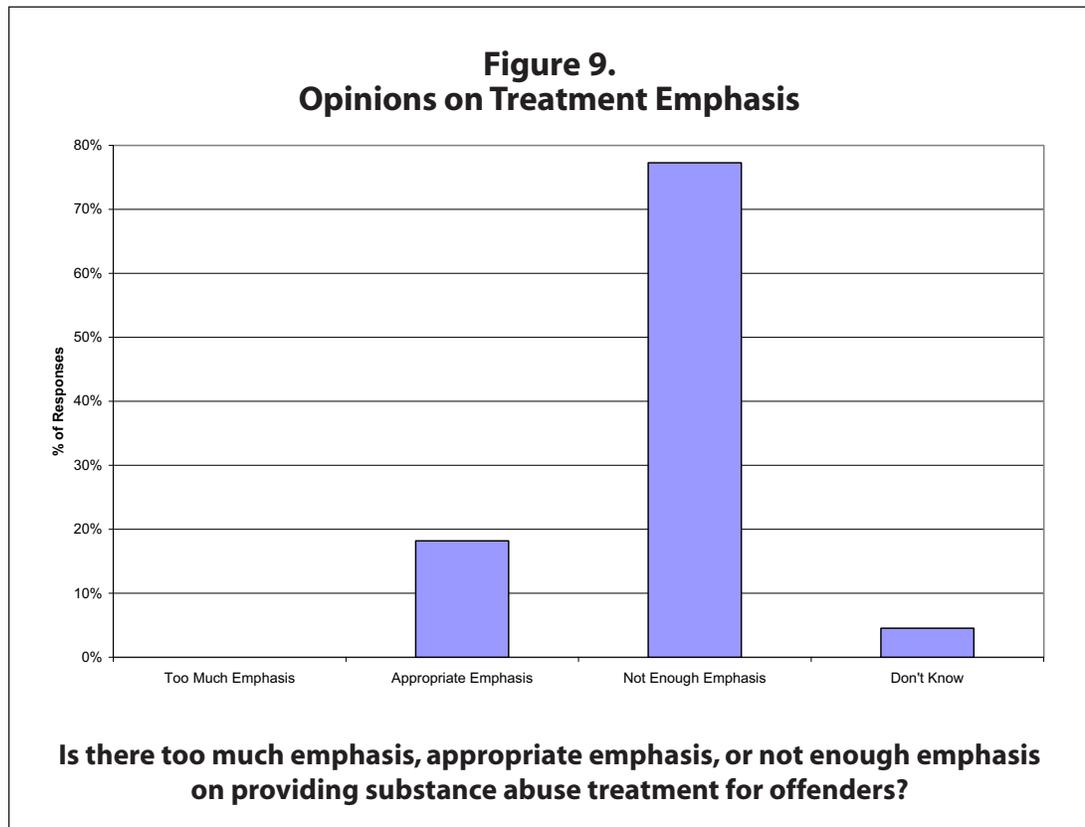


Figure 8, *Information Needed to Determine Substance Abuse vs. Percentage of Time Available*, compares information that is **most important** to judges to help determine if a defendant is substance-involved with how often judges estimate they **have** this information to help them in sentencing.

Items that judges indicated were most important in determining if a defendant is substance-involved include criminal history; TASC recommendation; treatment history; and treatment provider recommendation or clinical assessment. The items that judges indicated were most frequently available to them included criminal history, charge, and recommendations from the prosecution and defense.

Much of the information that judges need to determine substance involvement is not frequently available. In fact, criminal history information is the only item that judges indicated was useful that is reported to be consistently available. Although criminal history is not clinical in nature, judges can often see crime patterns that would indicate substance involvement (for example, multiple drug charges or escalating property offenses). Several judges indicated that TASC reports and other treatment-specific information is more available at violation of probation hearings, and in drug court settings.

According to the judges, Public Defender Psychoforensic evaluations are among the least needed and the least available information helpful to determine substance abuse treatment placement. These results also show that judges want clinical information and treatment recommendations, but not from parties involved in the adversarial process (prosecutors and defense attorneys).



As shown in Figure 9, *Opinions on Treatment Emphasis*, the great majority of judges (78 percent) indicated there is not enough emphasis on treatment. Fewer than 20 percent of judges indicated there was appropriate emphasis on treatment, and no judges indicated there was too much emphasis on treatment.

Only one judge who indicated that there was appropriate emphasis on treatment made a comment: “For the people I sentence, expanded community residential and outpatient treatment would be much more beneficial and more in line with sentencing guidelines.”

Almost all remaining judges indicated there was not enough treatment, there are long waits for admission, and there is a lack of services in the community.



Selected Comments:

“Too many people wait too long, often in custody (until the maximum Level V time for a misdemeanor offense) waiting for beds, monitoring equipment, etc.”

“...This community needs aftercare services. I suspect that some offenders would benefit from and cooperate with community-based programs short of Level IV and Level V if there were more inpatient beds in the community.”

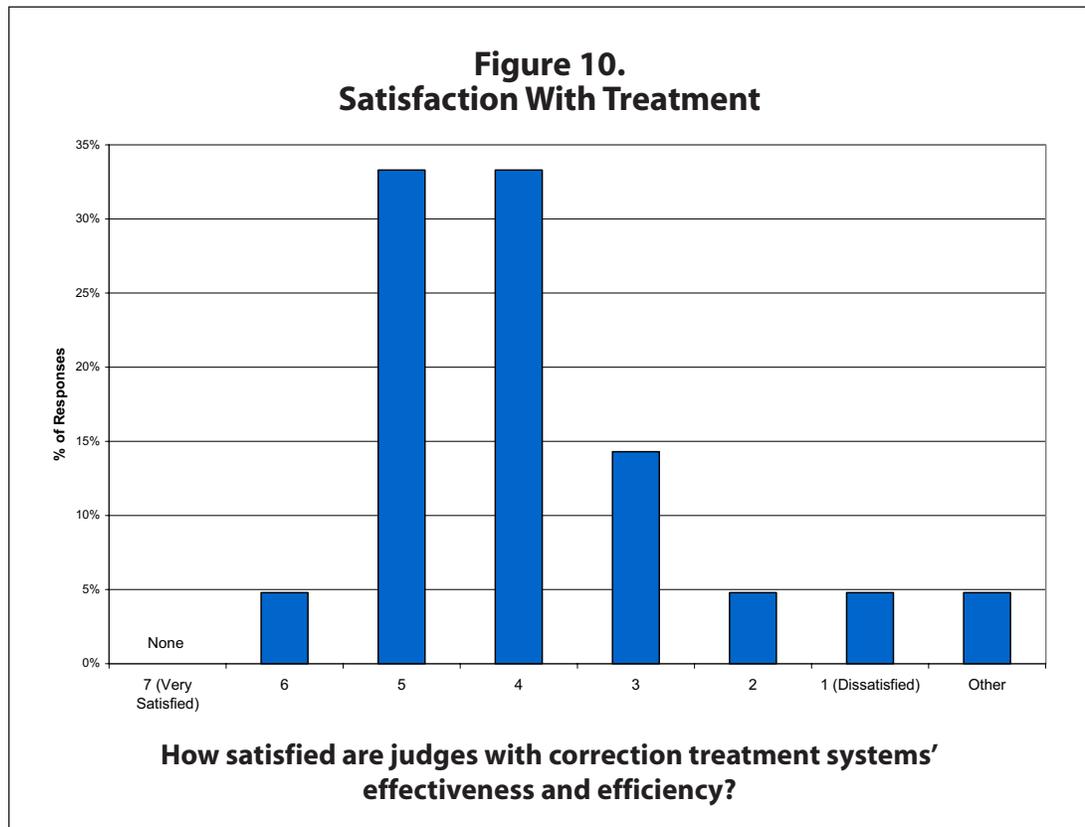
“More offenders in need of more treatment than is being provided.....”

“...Community care is very “iffy.” There are not enough Level IV CREST slots to handle all KEY graduates. There are not enough RCD slots for community placement. Greentree needs an aftercare and/or transition component.”

“There are frequent waiting periods for IV and V treatment. Sometimes the sentence is about to expire before a bed or space becomes available.”

“There is often a significant delay for offenders waiting to enter drug treatment. Treatment options (modalities) limited.”

*“80% of crime is drug driven”...
“most offenders need treatment”...
“80% of those arrested have serious addiction problems.”*



As shown in Figure 10, *Satisfaction with Treatment*, in response to the question “How satisfied are you with the effectiveness and efficiency of Delaware’s system for providing correctional treatment to substance-involved offenders?” 34 percent of judges indicated they were moderately satisfied (a score of 4), and another 34 percent indicated they were relatively satisfied with Delaware’s system (a score of 5). No judges indicated they were “very satisfied.”

Regardless of the level of satisfaction indicated, when asked to provide a rationale for their selection, almost all judges commented on weaknesses in the treatment system. These stated weaknesses included:

- Long waits for treatment
- Lack of services
- Lack of overall coordination and treatment options
- Need for more options (modalities and variety).



Selected Comments:

“It takes too long and there are insufficient efforts to supportafter return to the community.”

“The more services available the better.”

“...the treatment programs, while effective for some defendants, are not for the vast majority.”

“There is normally a waiting list for treatment slots. A Level V (misdemeanor) sentence can sometimes be completed before the person gets into a program.”

“...I believe more beds in residential programs are needed.”

“We have some good programs but they lack overall coordination. There is a need to use programs as designed not as convenient. Community treatment needs expansion to include IOP services...”

“We need more options/beds ... Delay is a major problem ... Also need a range of modalities ... confrontational programs don’t work for everyone.”

“Need more treatment options and more treatment slots.”

“They have a nationally recognized program which is reducing recidivism. Problem is lack of slots/beds.”

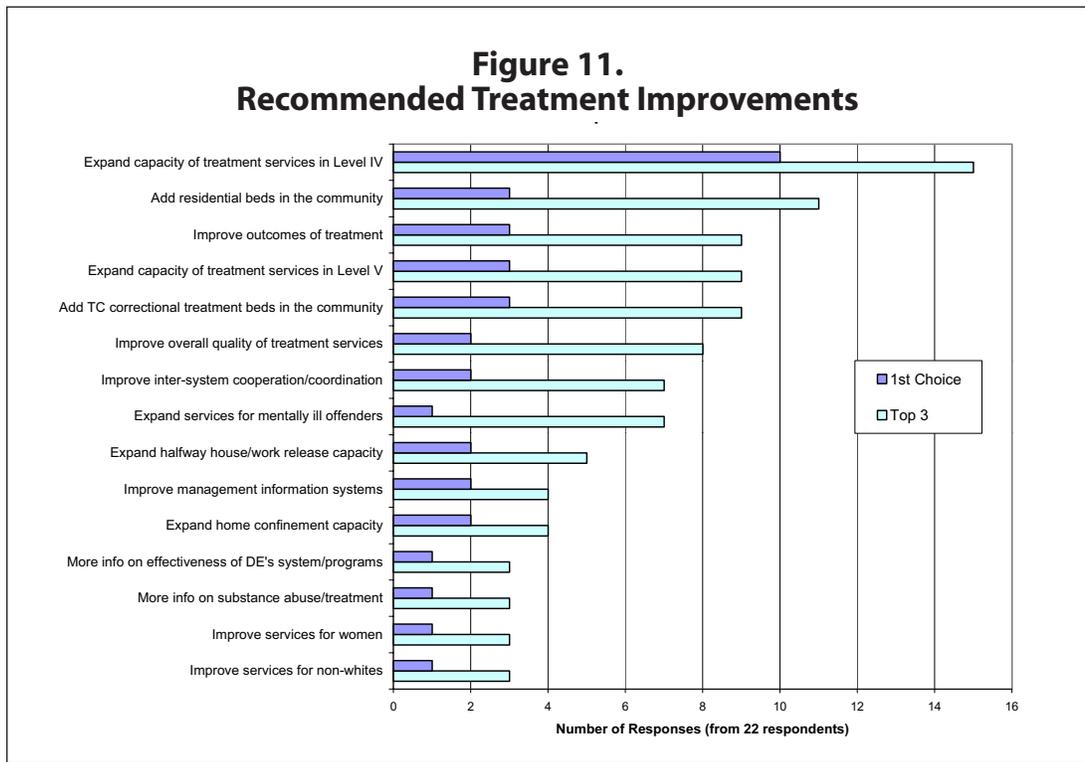


Figure 11, *Recommended Treatment Improvements*, shows how judges ranked needed improvements in the treatment system for offenders. Responses are presented as “top choice” and “top three choices.”

Judges indicated strongly that more services are needed for offenders, primarily in the community. The top choice of judges, as well as the response most frequently included in the top three choices, is to expand the capacity of treatment services in Level IV. Judges indicated they want to see expansion of residential beds and TC residential beds in the community.

Judges also showed a strong preference for improving the quality of treatment services as well as improving treatment outcomes.

Discussion

The numbers of judges and judicial officers that responded to the survey, along with their high estimates of the numbers of substance-involved offenders they sentence, underscores the emphasis that judges place on rehabilitation as well as the burden that substance abuse in the offender population places on the judiciary. The availability of substance abuse treatment clearly influences how sentences are structured in Delaware, with most judges indicating a willingness to depart from sentencing guidelines to secure treatment for the defendants they sentence.



Although judges do not receive regular education or information on substance abuse issues or treatment programming interventions, their responses and comments indicate a rather sophisticated understanding of treatment methods and effectiveness. And while judges rate treatment in Delaware fairly highly, their comments reflect some skepticism based on their experiences.

Responses to the judges' survey need to be taken in an overall context. While judges indicated they might sentence fewer people to Level V if treatment were reduced, they also strongly indicated a need for more effective community based services and indicated they would use them. And judges resoundingly agreed that the overall capacity of and emphasis on treatment was insufficient.

Under Delaware's structured sentencing system, judges fashion sentences designed to meet multiple goals. Unless they are confident that conditions for treatment will be met in a timely fashion and that positive treatment results will occur, judges are likely to choose higher levels of supervision to protect the safety of the public.

Concerns have been expressed by members of the judiciary and others regarding whether or not judges should sentence offenders to specific treatment programs in the first place. While treatment placement and activities are arguably clinical in nature, clinicians and treatment experts cannot work in a vacuum when dealing with offender clients. If people are committing crimes serious enough to come under the jurisdiction of the Superior Court, treatment placement and participation are no longer simply clinical issues. Failing to incorporate justice system issues and involvement would remove the powerful leverage and incentives that the justice system can offer that lead to offender client engagement, retention, and positive outcomes (Taxman and Cronin, 2000; Taxman, 2000).

Finally, it appears from the survey results that judges would support a reconfiguration of treatment, with Level V treatment reserved for offenders who need the structure of incarceration to respond to treatment or who would be sentenced to incarceration based solely on their crime and criminal history. Effective community-based residential treatment that was responsive to the needs of offenders and the courts would certainly be utilized for sentencing.



Section V: Delaware's System: Strengths, Weaknesses, and Recommended Next Steps

Delaware has responded to high levels of substance abuse in the offender population by making rehabilitation a primary goal of criminal sentencing, and developing and extensively expanding substance abuse treatment services for offenders. Results from the judges' survey indicate that rehabilitation is a priority goal of the judiciary, and it is also clear that staff in the Department of Correction and other justice and treatment professionals are committed to this goal. It is difficult to find any other state jurisdiction where support for rehabilitation and recovery from substance abuse is so widespread throughout a justice system.

Delaware has many important strengths in which practitioners and policymakers should take pride. The proportion of offenders who are able to access treatment, especially in Level V, is unmatched compared to other jurisdictions. There is system-wide support for offering treatment as a means to interrupt the criminal activity of substance involved offenders. The Department of Correction and the judiciary are fully engaged in this effort, and resources are in place both through the Department of Correction and the Division of Substance Abuse and Mental Health to try to meet the needs of this population.

A variety of other offender programming is also in place to augment and complement substance abuse treatment services, including (but not limited to) bootcamp, violation of probation centers, work release, intensive supervision, reentry programs and home confinement. There is unquestionably a rich array of resources with which to work.

Nonetheless, when reviewing the system in the context of evidence-based practices, Delaware is missing opportunities that would no doubt improve outcomes and lead to better resource management.

Delaware is not alone. Many jurisdictions have put programming in place to manage substance-involved offenders. However, even when proven program models are implemented and replicated, outcomes can be less than optimal unless a more systems-oriented approach is adopted. States end up with a hodgepodge of programming that is not well integrated or well understood, and that does not have the desired impact on recidivism or correctional resources. As noted in the literature, when model programs are expanded rapidly and without sufficient infrastructure support, program delivery may be compromised. To maintain program fidelity, the system must focus on establishing clear goals, ongoing training and ongoing quality control that focuses on and supports good outcomes. Policy oversight and guidance is necessary to assure consistency and continued effectiveness.

The opportunity to rehabilitate offenders is very important to Delaware judges, correctional and other justice professionals, and policymakers. This is clearly evidenced by the level of funding and interest that correctional treatment has engendered over the last several years; by the efforts that staff make to secure treatment within a system that is not well equipped to support those efforts; and by a



judiciary that tells us that the need for treatment overrides the punishment aspects of sentencing in many cases. The system has evolved to a point where establishment of an infrastructure and capacity to manage treatment services for adult offenders more effectively is overdue.

Recommendations

1. Establish a system of screening and assessment so judges can order treatment conditions based on both the clinical and risk characteristics of offenders.

A system of screening and assessment should be established under the aegis of SENTAC, so judges can order treatment conditions based on both the clinical and risk characteristics of offenders. This information should be available for making sentencing decisions for both new crimes and probation violations. To accomplish this, priority populations of offenders who should receive substance abuse treatment services should be established. These populations should be defined in accordance with correctional and sentencing policy, as well as program design, capability and capacity. Resources that are currently devoted to this up-front work should be identified and evaluated, and shifted as necessary to accomplish this goal. The system should be designed to capture assessment information on the bulk of appropriate treatment candidates without causing delays in case processing, while encouraging more appropriate treatment and supervision.

Rationale:

Clinical assessments are conducted on all offenders who are admitted to treatment services, both in the institutions and in the community. However, information from assessments and ensuing recommendations for program placement is not generally available to judges at time of sentencing, and assessments are routinely conducted *after* program admission. In a truly integrated system, decisions about substance involved offenders would be made based on both justice and treatment information. While this occurs more often in drug court and for probation violators, most decisionmaking related to conditions for treatment contained in court orders is made primarily based on justice system information such as criminal history.

Although clinical assessments appear to be routinely conducted, assessment information is not always used to develop differentiated treatment plans designed to meet the needs of individual offenders. Unless offenders present security risks or are otherwise significantly inappropriate (because of uncontrolled mental health symptoms, for example), they are admitted to correctional treatment programs, especially if they have a court order. One problem with this approach is offenders may be admitted to programs that will not be effective for them. While the system is actively involved in identifying offenders with substance abuse problems, the system is not doing a good job of identifying *which offenders are appropriate and amenable for different types of treatment*.

Failure to sort clients effectively into different programs and approaches may be detrimental to program operations and may be hurting rehabilitation efforts. In addition, use of long-term treatment for those who are not appropriately placed or



who may not need it wastes valuable resources. Outcome measurements can become flat – with successful outcomes for appropriate clients being diluted by poor outcomes for clients who may have been inappropriate for that particular program approach. Likewise, the inclusion of inappropriate persons may impair treatment effectiveness for those appropriate for the program. And in Delaware, repeated treatment failures by offenders under community supervision can contribute to an accumulation of probation violations, increased use of incarceration, and the creation of more serious criminal histories.

Information from assessments does not routinely follow the defendant through the system. As an example, pretrial defendants in the Six-For-One program at Howard Young Correctional Institution receive clinical assessments, but this information is not usually made available at sentencing. Thus, while this program provides an institutional benefit by stabilizing a difficult-to-manage population, and observations indicate that defendants' time is used productively, its benefits are limited. This program must be viewed as a pre-treatment program and its success should be measured based on how many people continue in treatment after sentencing. The nature of the population and the short-term duration of the program for many defendants, early termination due to resolution of the pending charges, and the lack of consistent referrals to continuing treatment upon release run counter to the research that supports longer-term treatment. As a result the opportunities offered for appropriate placement and treatment are missed.

2. Expand community-based services for substance-involved offenders to include residential and intensive outpatient services.

Community-based services specifically for substance-involved offenders should be expanded to include residential and intensive outpatient services. Any new residential programming should include transitional care (perhaps in the form of intensive outpatient treatment) and aftercare in the original design. Consideration should be given to creating longer term correctional TCs in the community to provide initial care. CREST could then be used to provide transitional services as designed. This would have a positive impact on the use of Level V beds and support offender movement through a planned treatment continuum.

Rationale:

Currently, there is no clear agreement about which offenders should receive priority for institutional and non-institutional treatment services. Misdemeanor offenders sentenced by judges and commissioners in the Court of Common Pleas and the Family Court are ordered into Level IV and V long-term programs. Judges of all courts have indicated they would sentence fewer people to Level V if more suitable options were available in the community. Studies have verified that those with serious drug problems who receive a full continuum of care have the best outcomes, but retaining offenders throughout a planned continuum has proven elusive in Delaware and elsewhere (Delaware Sentencing Accountability Commission, 2002; Eisenberg et al., 2001).



Because outcomes were positive early on, KEY and CREST were expanded rapidly, with a significant amount of initial expansion occurring in Level V facilities. These decisions were based on the laudatory goal of providing treatment to every inmate that needed it. However, even with the emphasis on expansion of CREST following the research findings that showed the effectiveness of transitional services, not enough CREST beds or other community-based services are in place to provide transitional and aftercare services for all KEY graduates. This has influenced sentencing practices, and results from the judges' survey indicate that some offenders are sentenced to Level V programming because of actual or perceived limitations in community programming. There are not enough suitable community-based residential beds for those offenders who might otherwise receive community (Level III or Level IV) sentences.

Judges also noted a lack of variety in program approaches. Not all offenders need or will respond to approaches used in therapeutic communities. And while long-term residential treatment is perhaps the best approach for people with serious substance abuse problems, many offenders would likely respond to shorter-term residential stabilization and treatment combined with longer term intensive outpatient treatment and recovery support services.

3. Examine outcomes of Level IV and V correctional and community-based programs.

Additional research should be conducted by the Delaware Sentencing Research and Evaluation Committee and the Statistical Analysis Center to examine outcomes of Level IV and V correctional treatment programs. Likewise, long-term outcomes for Level IV offenders placed in community-based residential treatment should be studied. Research should examine both clinical and justice characteristics of research subjects to begin to determine the *types* of offenders that respond best to different treatment interventions. Close examination of the processes in which offenders move through the treatment continuum should also occur. This research should inform policymakers in reallocating treatment resources to serve the most clients using evidence-based treatment practices while producing the best outcomes and conserving correctional resources.

Rationale:

Outcomes information on correctional treatment programs is not compiled routinely, but is developed through special research projects funded periodically by the General Assembly or through Federal grants. As such, the system does not know how successful it is on an ongoing basis. No recent studies have been produced that demonstrate the effectiveness of non-DOC community based programming in treating offenders. In addition, there is no continuing effort to monitor how the system is working operationally, including monitoring waiting lists, program usage, or admission and completion rates. Many findings in this report suggest changes in how treatment for offenders might warrant reconfiguring. However, there is no data that exists to guide these changes.



4. Develop policies, procedures, inter-agency agreements and data capabilities for managing substance-involved offenders.

A process should be initiated under the aegis of SENTAC to develop policies, procedures, inter-agency agreements and data capabilities for managing Delaware's substance-involved offender population. To begin this work, an endeavor to educate a wide range of justice and treatment practitioners concerning evidence-based practices for substance-involved offenders to develop a common understanding of and vision for improving offender treatment systems and services should be supported. The Delaware Sentencing Research and Evaluation Committee is currently identifying resources that could be used to begin this process.

Rationale:

Delaware's system operates informally. Very few stated policies exist to provide guidance to decisionmakers on how to manage substance-involved offenders. While offenders are eligible to be admitted to community-based programming operated under the auspices of DSAMH, policies and procedures for coordinating the delivery of these services with the justice system are not well defined, and questions regarding priority of these services for offenders have not been resolved. In the absence of defining strategies or detailed policy agreements, sentencing guidelines are inadequate to support judicial decisionmaking for substance-involved offenders.

There is no central system for managing information related to offenders in treatment or offenders who have been ordered to treatment. Studying treatment outcomes for offenders thus requires additional effort for data verification, and to ascertain information that is not contained in existing, and somewhat limited, databases. Data on community-based programs (including data on the Six-For-One program) is maintained by DSAMH and is not available to justice system analysts or policymakers. Delaware has invested significant resources to provide substance abuse services for offenders, but does not have regular access to program evaluations. In fact, simple information such as numbers of admissions and discharges is not available routinely.

Communication in general related to programming, program availability, and client status is inconsistent and ineffective for sentencing, system management and client management. The tracking study showed that most offenders are placed in court-ordered treatment, but the judges have a different perception. In fact, judges may not order certain types of treatment if they perceive that it is not readily available. Many of the delays associated with placing offenders in court ordered treatment are also due to communication problems, with judges not having easy access to other courts' or judges' sentences, open charges, or other justice information. Technical problems or issues that prevent treatment placement are frequently unresolved because information is not shared in a timely fashion. The resulting delays in treatment placement too often result in probation violations for people held in the community.

As noted in our earlier report and reflected in the work conducted for this report, communication and information management and exchange capabilities have not kept pace with the rapid expansion of the treatment system, and are not sufficient to accommodate the many ways offenders enter and participate in correctional treatment.



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Appendix A

EFFECTIVE MANAGEMENT OF DRUG-INVOLVED OFFENDERS

A Report to Governor Michael N. Castle

Developed by

The Drug Involved Offender Coordination Committee

Richard S. Gebelein, Chairman

March 12, 1992

Drug Involved Offender Coordination Committee Members

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Charles Butler, Esq., Department of Justice
Angelo Falasca, Public Defender's Office
Hon. Robert Watson, Commissioner of Correction
Sharon Letts, Delaware Council on Crime and Justice
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Hon. Marlene Lichtenstadter, Chairman, Parole Board
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I. INTRODUCTION

On December 5, 1990, the Criminal Justice Council held a day-long planning workshop. During this meeting, several topical areas were identified as priorities for the criminal justice system during the coming year. The top priority was drug abuse and its impact on the system. Follow-up meetings of the Council were held on the subject in June and September, 1991. During those meetings, the problems associated with managing drug-involved offenders were discussed. In addition, a panel of specialists from the treatment, academic, and criminal justice communities discussed issues and trends, and offered suggestions for improving our system of dealing with drug-involved offenders.

As a result of that meeting, the Drug Involved Offender Coordination Committee was established. The Committee, chaired by Superior Court Judge Richard S. Gebelein, operates as a joint committee of the CJC and the Drug Abuse Coordinating Council. The committee was charged with designing a system to more efficiently and effectively manage drug-involved offenders with the end goal of reducing both drug use and crime in this population.

Membership consists of many of the decision-makers and leaders who have a stake in managing this population, and includes representation from the community at large. Members represent the Division of Alcoholism, Drug Abuse, and Mental Health, the Department of Correction, the Courts, the Attorney General, the Public Defender, the Budget Office, the Controller General's Office, and a variety of other criminal justice, treatment, and not-for-profit agencies and organizations. Representatives from the Legislature, as well as additional representatives from the law enforcement and corrections communities were added to the original committee to further broaden the representation.

The Committee met three times. Committee meetings were structured to facilitate dialogue, information exchange, and goal-oriented problem solving. A notebook of research and information articles was compiled, disseminated, and updated on a regular basis; several committee members contributed to this effort.

During the first meeting, the group agreed to focus on offenders involved with illegal drugs. The committee agreed that alcohol is a drug, and problems associated with alcohol abuse (including DUI) warrant attention. We also recognize the problems associated with the dually diagnosed; persons with substance abuse and mental health problems, for example. This report also does not address the issues involving juveniles who are involved with drugs. We recognize the need to arrest the progression of addiction at an early age, and believe that efforts that focus on the youthful offender population would have a substantial impact. However, because the adult drug involved offender population is so large and problematic, we decided to limit the scope of our efforts to this specific population. We hope that some of what we've learned and some of what we are attempting to accomplish can be translated to benefit other populations as well.

The results of this Committee effort which follow represent a collaborative effort. Committee members were well-informed and enthusiastic, and demonstrated both cooperation and commitment to this issue.

II. WHAT WE LEARNED

Over the course of the three months since this committee was appointed, we have shared information to discover and understand the effectiveness of treatment for the drug-involved offender and to better understand the problems associated with managing drug involved offenders in Delaware's criminal justice systems.

A. What the Research Says About Offenders and Treatment

There is a large body of research available on drug use and crime and on the effectiveness of drug treatment for offenders. Major findings from this research follow. More detailed information is available upon request.

- **THERE IS A STRONG LINK BETWEEN DRUG USE AND CRIME.**
- **FOR ADDICTED OFFENDERS, REDUCING THE AMOUNT OF DRUG USE REDUCES THE RATE OF CRIMES COMMITTED.** This has been substantiated by several large-scale controlled studies.

Addicted offenders support their addictions by committing crimes. In addition, by definition, addicted persons who buy and sell illegal drugs are involved in a criminal lifestyle. Some addicted offenders commit a disproportionate number of crimes to support their addiction. Studies have proven that eliminating or reducing the drug dependency of these offenders also reduces the numbers of crimes they commit.

In a study conducted by Robert L. Hubbard et al., (NIDA Research Monograph 86: Compulsory Treatment of Drug Abuse: Research and Clinical Practice), offenders ordered to treatment reported that they committed an average of 63.2 predatory illegal acts during the year before entering treatment. The first three months of treatment they reported committing an average of 4.9 predatory illegal acts; 3 to 6 months into treatment they reported an average of 2.3 predatory illegal acts. Another study found that drug abusers who are using drugs heavily report six times more criminal activity than drug abusers who are less addicted. Compulsory methadone maintenance for heroin users and compulsory participation in therapeutic communities have also shown reductions in both drug usage and crime.

- **CRIMINAL SANCTIONS BY THEMSELVES ARE NOT VERY EFFECTIVE IN REDUCING DRUG USE AND CRIMINALITY OF DRUG INVOLVED OFFENDERS.** Without some kind of treatment intervention, offenders who are incarcerated return to the community still addicted; they return to their criminal activities as well.
- **JOINT EFFORTS BY TREATMENT AND CRIMINAL JUSTICE ARE NEEDED TO REDUCE DRUG USE AND CRIMINALITY. WE CAN SOLVE EACH OTHER'S PROBLEMS.** 60 to 80% of offenders abuse drugs and/or alcohol. The criminal justice system can play a major role identifying substance abusers, referring them to treatment and holding them in treatment with legal pressure.
- **TREATMENT WORKS.** No single treatment intervention works for everyone. Some people don't recover no matter what the intervention. Some people recover on their own, while others need a treatment intervention. However, it is indisputable that treatment works.
- **COMPULSORY TREATMENT WORKS.** Several studies have indicated that there is no significant difference between outcomes of those who are court-ordered to treatment and those who enter treatment voluntarily. The major factor in treatment success is length of time in treatment.

- A CONTINUUM OF TREATMENT OPTIONS SHOULD BE IN PLACE TO INCLUDE DETOXIFICATION, METHADONE MAINTENANCE, THERAPEUTIC COMMUNITIES, LONG-TERM RESIDENTIAL, SHORT-TERM FLEXIBLE STAY RESIDENTIAL, INTENSIVE OUTPATIENT, AND RELAPSE PREVENTION INCLUDING SKILLS REMEDIATION, AFTERCARE AND SOCIAL SUPPORT.
- OFFENDERS AND OTHER CLIENTS SHOULD BE PROVIDED THE LEAST INTENSIVE AND INTRUSIVE TREATMENT COMMENSURATE WITH THE SEVERITY OF THEIR ADDICTION AND THEIR OTHER SKILLS FOR LIVING. This approach is cost-effective and more likely to have success with the greatest number of offenders.
- CLIENTS SHOULD BE MATCHED TO APPROPRIATE TREATMENT BASED ON COMPREHENSIVE AND RELIABLE ASSESSMENTS.
- CLIENTS SHOULD BE BOTH ELIGIBLE AND APPROPRIATE FOR TREATMENT. Eligibility means that they must meet both treatment and criminal justice criteria for admission. Appropriateness means that they should be able to benefit from the program.
- DRUG ABUSE CAN BE BOTH CHRONIC AND RELAPSING. LAPSES AND RELAPSES ARE THE NORM, NOT THE EXCEPTION. Studies have shown that 60 to 80% of those who succeed in treatment relapse, perhaps several times, before attaining successful recovery.
- URINE MONITORING SHOULD BE PART OF COURT-ORDERED TREATMENT. Urine monitoring alone has shown to be effective at reducing or eliminating drug use in the “casual user” population. It can identify people who need rug treatment, as well as identify drugs of choice. In addition, it can be used as a treatment tool to measure progress in treatment and assess the need to increase the intensity of treatment and/or sanctions for addicted offenders.
- TREATMENT ALTERNATIVES TO STREET CRIME (TASC) IS A PROVEN CASE MANAGEMENT MODEL TO BRIDGE THE TREATMENT AND CRIMINAL JUSTICE SYSTEMS.

B. Managing Drug Involved Offenders in Delaware: Defining the Problem

We estimate that at least two-thirds of offenders in Delaware are drug-involved, committing drug offenses and/or committing other crimes because of their drug involvement.

Caseloads in the Courts and the criminal justice system have increased dramatically, nearly doubling during the last three years; much of this increase can be attributed to the increased numbers of drug-involved offenders coming through the system. The literature shows that drug offenders commit multiple crimes to support their addiction. There is well-documented evidence that substance abuse treatment can substantially reduce both the drug use and criminality of drug-involved offenders.

As we examined the way we currently manage the drug involved offender population, two major issues emerged. First, there is a lack of coordination and collaboration among the courts, the Department of Correction, and the treatment delivery system which results in the inefficient utilization of existing resources. Second, existing treatment resources are inadequate to meet the needs of the drug-involved offender population. These two issues compound and confound each other, and make it impossible to remedy the situation with anything less than a comprehensive and systematic approach.

Coordination Issues

Sentencing orders are being imposed with conditions of substance abuse treatment as part of the sanctions imposed at all five accountability levels. The treatment and criminal justice systems are complex, and there is no systematic process in place to assess, refer and case manage offenders in treatment.

Philosophical differences exist between the criminal justice and treatment systems. In part, these differences result in neither system taking full responsibility for the substance abusing offender population.

There is no mechanism or entity in place to resolve problems between the systems or to resolve problems related to specific offenders in treatment. No formal feedback system is in place to inform the courts or other criminal justice agencies about offender needs, progress, or outcomes in treatment either aggregately or for specific outcomes.

No priority has been established regarding which offenders should utilize limited treatment slots. There is not enough focus on outcomes and no process is in place to effectively evaluate programs in terms of outcomes. There is no mechanism in place to encourage effective cooperative relationships between treatment and supervision providers to improve outcomes.

Substance abuse assessments are conducted by the Screening and Evaluation Team which operates out of the Division of Alcohol, Drug Abuse and Mental Health. The current assessment process is far removed from the criminal justice system, and assessment results are not often available at decision points in the criminal justice system. Assessment instruments are inadequate to make treatment placement decisions for drug addicts and/or offenders. No tracking system is in place to ensure or document offender admission, treatment progress, or outcomes.

Treatment Availability

Treatment services available in Delaware are inadequate to meet the needs of the offender population. In 1986 and 1987, several "offender-dedicated" treatment programs were developed. At that time, a 12-bed residential treatment program began, and an intensive out-patient treatment program for 30 offenders per year was started. In addition, approximately \$125,000 was used to provide offender-dedicated outpatient services. In 1989, an additional \$200,000 was added to the residential budget, and contractual and funding responsibilities were transferred to the Department of Correction. The additional money was utilized to purchase four more residential beds in an existing short-term program.

Since 1986, the number of drug-involved offenders coming through the criminal justice system has increased dramatically. During the last three years, criminal case filings in the Superior Court have increased 61%; much of this increase can be attributed to increased drug cases. Drug arrests have increased over 200% since 1986, from 1214 to 2652 in 1990. Likewise, the number of drug offenders sentenced or detained to correctional facilities has increased from 571 in 1986 to 1679 admissions in 1990. Currently, there are approximately 15,000 people on community corrections in Levels I through IV; of these, 21% had a drug offense as a lead charge. The only charge with a higher frequency of occurrence is DUI and other traffic offenses.

Although drug involved offenders are clogging our courts and prison systems, concomitant increases in treatment resources have not occurred. Treatment admissions have remained relatively flat, as have treatment budgets. All federal and state resources dedicated to treatment services for all adult Delawareans total approximately \$6 Million, compared to a corrections budget nearing \$80 Million excluding the \$55 Million in capital costs associated with prison expansion this year.

Offender dedicated treatment resources are even more out of balance. Three hundred eight seven offenders were admitted to outpatient treatment, representing less than three percent of the community corrections population. Less than one percent were admitted to a community based residential program. There are 70 in-prison therapeutic community beds. As of June 30, 1990, 628 of the 3635 offenders in our Level V facilities were there for drug offenses; this does not count those drug addicts incarcerated for other criminal acts. Funding for Greentree, a treatment program which operated at the Delaware Correctional Center, was cut entirely in 1991.

Some representative problems that result include:

- r Offenders court-ordered to treatment have occupied prison beds at the same time residential facilities have openings. More importantly, there is not a record of offenders court ordered to wait in Level V for a treatment bed. Some offenders serve their entire sentences without getting treatment.
- r While treatment availability is inadequate to meet the needs of all offenders, the existing programs are inefficiently utilized.
- r There is no central data base to describe the drug-involved offender population or to make justified program recommendations.
- r Judges do not know with any degree of certainty that their sentencing orders are fully implemented.
- r In some instances resources are wasted by multiple assessments being ordered and paid for as offenders are referred by different sources, e.g. the Public Defender, the Court, Probation, etc.

In order to resolve these and other identified problems, the Committee has developed an action plan to more effectively manage the drug-involved offender population.

III. ACTION PLAN FOR EFFECTIVELY MANAGING DRUG-INVOLVED OFFENDERS

GOAL: ESTABLISH A COMPREHENSIVE SYSTEM FOR EFFECTIVELY MANAGING DRUG-INVOLVED OFFENDERS IN DELAWARE FROM ARREST THROUGH FINAL DISCHARGE FROM THE AUTHORITY OF THE CRIMINAL JUSTICE SYSTEM. THE SYSTEM SHALL BE COST-EFFECTIVE BY MAXIMIZING RESOURCES, AND SHALL CONTAIN STRATEGIES TO PROTECT THE PUBLIC FROM VIOLENT OFFENDERS AND REHABILITATE OFFENDERS WHO DISRUPT SOCIETY BECAUSE OF THEIR INVOLVEMENT WITH DRUGS.

Objective 1: Develop a broad-based consensus of all stakeholders on the scope and definition of the problem and the activities needed for solution.

Strategies:

- a. Develop and disseminate a description of the problem to all stakeholders.

Implementation status: Problem statement developed.

- b. Establish a forum whereby stakeholders can participate in the development and implementation of the plan.

Implementation status: The Drug Involved Offender Coordination Committee contains representatives that represent the major stakeholders in developing a more coordinated and effective approach for managing the drug-involved offender. In addition, as a result of Delaware's participation in a conference on Substance Abuse and Its Impact on the Courts, committee membership has been expanded to include representatives from the Legislature as well as additional representatives from law enforcement and corrections.

A recommendation on the future of this strategy is included in the Recommendations section of this report.

- c. Develop an approach to gain support from the wider criminal justice and treatment communities, other governmental entities, the private sector and the general public.

Implementation status: Two articles have appeared in the Criminal Justice Council Issues Update newsletter which highlight various issues related to this report. In addition, upon release of this report, presentations will be made and the report will be disseminated to the Criminal Justice Council, the Drug Abuse Coordinating Council, the Legislature, and SENTAC.

Objective Two: Establish a system, based on the Treatment Alternatives to Street Crime model (TASC) to identify, assess, refer to treatment, and case manage offenders who commit crimes because of their involvement with drugs.

This system should include measures to ensure accountability of the offender and accountability of both the criminal justice and treatment systems. These measures should include, but not be limited to, urinalysis, program evaluations, cost efficiency analyses, availability of information on specific drug-involved offenders, and management reports to the treatment and criminal justice communities and other interested parties.

We believe that establishing such a system would provide a structure to enable the criminal justice system to more effectively use treatment resources in the community and criminal justice systems, basically making better use of existing and future resources. In addition, it would provide a vehicle for acquiring needed resources in the future.

Strategies:

- a. The criminal justice system should develop and/or adopt a valid and reliable offender-specific substance abuse assessment instrument which measures the level of drug involvement of the offender as well as his or her risk to the community. This assessment should be conducted on a population of drug-involved offenders at the pre-trial stage of criminal processing, and at other points that coincide with criminal justice decision-making (e.g. probation violations). The assessment instrument and process will replace the current SET process for targeted offenders.
- b. A centralized mechanism should be established to refer appropriate offenders to treatment as an alternative or supplement to additional criminal sanctions.
- c. Policies, procedures, and mechanisms to conduct urinalysis in conjunction with the assessment and treatment processes should be established.

- d. A system to provide case management services for offenders in treatment should be established to ensure accountability of the offender and accountability of the treatment and criminal justice systems. Assessments, referrals, admissions, discharges, and treatment progress will be documented on all offenders. Progress reports on specific offenders in treatment should be available to the courts and the probation office, and regular management reports should be published.
- e. A data base of all offenders assessed, referred and case managed should be maintained for the purpose of evaluating procedures and programs and for making additional program recommendations to the criminal justice and treatment systems. Emphasis on programs for underserved populations such as women and HIV positive individuals will be given as needed. This data will also be used to develop priorities for offender participation in treatment and for making other operational and management decisions.
- f. A process to provide training to the criminal justice and treatment systems on effective strategies for managing drug-involved offenders in treatment should be established.
- g. The system will operate to make recommendations to the Courts or other authoritative bodies for exceptional cases and for treatment failures. In addition, it will function to resolve problems and disputes between criminal justice and treatment providers, as well as for the larger criminal justice and treatment systems.
- h. Mutually developed policies and procedures for eligibility, admission, discharge, success, and failure criteria will be developed.
- i. Implementation status: The Superior Court was approved to receive \$75,000 in BJA Formula Grant Funds to begin the development of a program to achieve the above. State resources will be sought to augment this federal money, and will be used to fund case managers for the program. If received, the state funds will be used as matching funds for a grant application to the State Justice Institute, planned for submission March 1, 1992.

Objective 3: Create an environment in Delaware whereby objectives of this action plan can be optimally achieved.

Strategies:

- a. Budget recommendations should be developed to support the implementation of this action plan and to encourage the effective management of drug-involved offenders.

Implementation status: Efforts are underway now to develop a needs assessment design. Funding to conduct the needs assessment will be sought from federal sources. Once needs are identified, program designs with costs will be developed.

- b. Existing laws, regulations, policies, and procedures will be examined and modified, if necessary, to ensure they are consistent with effectively managing the drug-involved offender. These procedures will be agreed upon by both the criminal justice and treatment systems.

- c. Sentencing standards and practices should be examined and modified, if necessary, to ensure they are consistent with effectively managing the drug-involved offender.

Implementation status: SENTAC is in the process of conducting this evaluation. In addition, through a grant from the State Justice Institute, a benchbook section on sentencing drug involved offenders will be developed.

IV. RECOMMENDATIONS

1. Establish a Treatment Access Center (TASC) to identify, assess, refer to treatment and case manage drug-involved offenders by legislation. A section of the legislation should include the establishment of a permanent subcommittee under SENTAC to function as a steering and advisory board. This subcommittee should include representatives from the criminal justice and treatment systems, as well as other persons with a stake in the management of drug-involved offenders.
2. Support existing treatment programs, both offender dedicated and non-offender dedicated, at current funding levels.

Although we recognize that available treatment is woefully inadequate to meet the needs of the offender population, we are reluctant to make specific program recommendations until we have better data on the needs of this population. We anticipate that within the next 12 to 18 months, we will be in a position to make cogent and well-developed recommendations for programming for offenders.

If additional resources are redirected toward this effort, our recommendation is to expand outpatient and intensive outpatient programming. Expanding these services would be the most cost-effective and would provide services to the largest population. In addition, dollars translate directly to client services, since no capital costs would be involved.

3. Redirect \$125,000 in existing state funds to support the Treatment Access Center under development with a small federal grant. This money should be utilized to fund permanent positions, and will be available as match to pursue additional federal funding.
4. A subcommittee of the above-referenced steering and advisory board should be assigned responsibility to propose modifications to current laws, policies, and procedures in order to incorporate treatment options as a supplement to existing criminal sanction.

Appendix B

Delaware Adult Offender Treatment Services

Survey of the Judiciary

April 2003

Last spring, SENTAC issued a report entitled “Sentencing Trends and Correctional Treatment in Delaware.” Among other things, the report concluded that treatment is interwoven into the structure of sanctions in Delaware, and that a large number of sentences are structured to suspend a portion of Level V upon treatment completion. These sentences are referred to as “addiction” sentences. This shift to the incorporation of substance abuse and other treatment into many criminal sentencing orders, occurring during the early 1990s and continuing to today, represents a major change in justice policy and practice in Delaware.

This survey is designed to assess judges’ practices, attitudes and opinions regarding treatment for adult criminal offenders.

Thank you for taking the time to complete this survey. The results will be used to help develop public policy related to treatment for incarcerated and other criminal offenders in Delaware. A summary of survey results may appear in a scheduled SENTAC report this spring.

Before completing the survey, please take some time to reflect on your sentencing practices related to adult substance-involved offenders. These survey results will remain confidential. However, we may wish to contact you by telephone at a later date to clarify responses or to explore certain areas in more depth.

1. Court of Jurisdiction: _____
2. Name (optional): _____
3. Telephone: _____
4. Email: _____

1. Do you sentence people to treatment at Levels IV or V?

- Yes
- No

If you answered “No” to this question, please do not complete the rest of the survey, but please return it per the instructions on page 9 . Thank you for your time.

2. In terms of your criminal caseload, about what proportion of the following crime categories do you sentence to treatment? Please give your answer as a percentage (e.g., 25% nonviolent felons)

- _____ Violent Felons
- _____ Nonviolent Felons
- _____ Felony Drug Offenders
- _____ Felony Drug “First” Offenders
- _____ Misdemeanor Drug
- _____ Misdemeanor Non-Drug
- _____ DUI
- _____ Other (please describe) _____
- _____
- _____
- _____

3. Are you currently a “drug court” judge – that is, do you preside over a special drug court calendar or docket as all or part of your criminal sentencing activities?

- Yes
- No

4. When you have evidence that a defendant is substance-involved, about how often do you impose a condition for treatment participation?

- 100% of the time
- 81-99% of the time
- 61-80% of the time
- 41-60% of the time
- 21-40% of the time
- Under 20% of the time
- Never or almost never

5. Please rank, in order of importance, the information that is most important to you in determining if a defendant is substance-involved, with “1” being the most important.

- _____ Charge
- _____ Criminal History
- _____ Treatment History
- _____ Recommendation from Prosecutor
- _____ Recommendation from Defense Attorney
- _____ Recommendation from TASC
- _____ Recommendation from Treatment Provider
- _____ Results of Substance Abuse Assessment
- _____ Familiarity with defendant from previous appearances
- _____ Presentence/pretrial report
- _____ Public Defender Psychoforensic Evaluation
- _____ Other (please describe) _____
- _____
- _____
- _____

6. About how often do you **have** the following information to help determine if a defendant is substance involved? (*Please estimate in percentages, and answer all that apply.*)

- _____ Charge
- _____ Criminal History
- _____ Treatment History
- _____ Recommendation from Prosecutor
- _____ Recommendation from Defense Attorney
- _____ Recommendation from TASC
- _____ Recommendation from Treatment Provider
- _____ Results of Substance Abuse Assessment
- _____ Familiarity with defendant from previous appearances
- _____ Presentence/pretrial report
- _____ Public Defender Psychoforensic Evaluation
- _____ Other (please describe) _____
- _____
- _____
- _____

7. About how many offenders have you sentenced during 2002 with any condition for substance-abuse treatment participation?

- _____ <25
- _____ 25-50
- _____ 51-75
- _____ 76-100
- _____ 101-150
- _____ 151-200
- _____ 201-250
- _____ 251-300
- _____ 301-400
- _____ 401-500
- _____ >500
- _____ Don't Know

8. When ordering treatment, do you usually designate a specific program (e.g., Key, Greentree, Thresholds, Crest)?

- Yes
- No

9a. In your opinion, is the need for substance abuse treatment a good justification for sentencing outside SENTAC guidelines? (*Please check all that apply.*)

- Yes, in excess of the sentence called for in the guidelines
- Yes, less than the sentence called for in the guidelines
- No

9b. Please discuss the rationale for your response to question 9a.

10a. If treatment programming at Level V were reduced or not available, do you think you would:

- Sentence **more** substance-involved defendants to Level V?
- Sentence **fewer** substance-involved defendants to Level V?
- Sentence the **same** number of substance-involved defendants to Level V for a **longer** period of time?
- Sentence the **same** number of substance-involved defendants to Level V for a **shorter** period of time?

10b. Please discuss the rationale for your response to question 10a.

11. If effective long-term residential treatment for offenders were more available in the community, would you sentence fewer people to Level V?

- Yes
- No

Why or why not? _____

“Addiction sentences” in Delaware have been defined as sentences to Level V or Level IV where an offender may be released early upon completion of court-ordered treatment. As an example, an addiction sentence might read: “Level V for 5 years, suspended upon completion of the Key program for 1 year Level IV Crest.”

The following four questions are related to addiction sentences only. If you do not impose these type of sentences, please skip to question #16.

12. In the past year, about how many “addiction sentences” have you imposed whereby a **Level V** sentence can be reduced upon treatment completion?

- _____ <25
- _____ 25-50
- _____ 51-75
- _____ 76-100
- _____ 101-150
- _____ 151-200
- _____ 201-250
- _____ 251-300
- _____ 301-400
- _____ 401-500
- _____ >500
- _____ Don't Know

13. In the past year, about how many “addiction sentences” have you imposed whereby a **Level IV** sentence can be reduced upon treatment completion?

- _____ <25
- _____ 25-50
- _____ 51-75
- _____ 76-100
- _____ 101-150
- _____ 151-200
- _____ 201-250
- _____ 251-300
- _____ 301-400
- _____ 401-500
- _____ >500
- _____ Don't Know

14. If treatment for incarcerated offenders (e.g. Key, Greentree) were substantially reduced or eliminated, about how many offenders under your control *today* would be held on an “addiction sentence?”

- _____ <25
- _____ 25-50
- _____ 51-75
- _____ 76-100
- _____ 101-150
- _____ 151-200
- _____ 201-250
- _____ 251-300
- _____ 301-400
- _____ 401-500
- _____ >500
- _____ Don't Know

15. If asked to modify “addiction sentences” for offenders you have sentenced within the last year because Level V treatment is reduced or eliminated, would you be more likely to:

- Order the offender to **complete** the full Level V sentence
- Reduce **a portion** of the Level V sentence for treatment in the community
- Reduce **all** of the Level V sentence for treatment in the community
- Other (Please explain): _____

16. Please rank the following programs in order of your usage, with “1” being the program you order most frequently:

- _____ Key (includes Key North, South, Webb, Village)
- _____ Crest (includes New Horizons, Crest North, Crest South)
- _____ Greentree
- _____ Recovery Center of Delaware (RCD) (includes Reflections, Alternatives)
- _____ Brandywine
- _____ SODAT
- _____ Kent County Counseling
- _____ Thresholds
- _____ NET Counseling Centers
- _____ Open Door
- _____ Other (please specify) _____

19. If you were able, what improvements would you make to Delaware's system of correctional treatment and other services? *Please rank in priority order, with "1" being your top priority:*

- _____ Expand capacity of treatment services in Level V
- _____ Expand capacity of treatment services in Level IV
- _____ Improve overall quality of treatment services
- _____ Improve outcomes of treatment
- _____ Expand services for mentally ill/dually diagnosed offenders (those with co-occurring substance abuse and mental health problems)
- _____ Improve cooperation and coordination between the treatment and the justice system
- _____ Provide/have access to more information on the effectiveness of Delaware's system/programs
- _____ Improve services for women
- _____ Improve services for African American and/or other non-white populations
- _____ Provide more information to the justice community on substance abuse and treatment
- _____ Improve management information systems
- _____ Add residential beds in the community
- _____ Add Therapeutic Community (TC) correctional treatment beds in the community
- _____ Expand halfway house/work release capacity
- _____ Expand home confinement capacity
- _____ Other (please describe):

End of Questionnaire

Thank you very much for taking the time to complete this survey. Your input is very valuable to assist in shaping justice policy in Delaware.

Please return this survey by October 1, 2003 to:

Beth Peyton
c/o SENTAC Sentencing Research Committee
Delaware Statistical Analysis Center
60 The Plaza
Dover, DE 19901

Comments on the Survey:



Appendix C

Technical Notes Related to the Survey of the Judiciary on Adult Offender Treatment Services

The initial survey form was drafted by staff and reviewed by the Research and Evaluation Committee members. In addition, the survey was sent out in a pilot fashion to several judges in Superior Court, and was revised based on this input. Surveys were distributed by mail to 59 judges and judicial officers throughout the state as follows:

- 15 Family Court Judges
- 16 Family Court Commissioners
- 9 Court of Common Pleas Judges
- 19 Superior Court Judges.

Follow-up postcards were sent as reminders. Upon preliminary analysis, judges in the Family Court reported that they did not sentence adults with conditions for treatment at Levels IV or V¹. However, after discussion with the Chief Judge of Family Court, some Family Court Commissioners *do* order people to Level IV and V treatment. The survey was then distributed to all family court commissioners. Due to time constraints and the high response rates from judges, surveys were not distributed to commissioners in Superior Court and the Court of Common Pleas.

The overall response rate to the survey was 53 %, and can be broken down as follows:

- 47 % Family Court Judges
- 44 % Family Court Commissioners
- 67 % Court of Common Pleas Judges
- 58 % Superior Court Judges.

Survey results were compiled only for judges and commissioners who indicated that they sentence people to treatment at Level IV or Level V (N = 22). All judges from the Court of Common Pleas and the Superior Court indicated they sentence people to treatment at Level IV and V, with the exception of one Superior Court judge who is new and does not yet carry a criminal caseload. Seven judges (two CCP and five Superior) indicated they were drug court judges.

Survey data were entered into a database and analyzed to compile and sort results. A number of the questions were open-ended (asking for a free-text response). These questions were sorted into like categories for analysis purposes when possible, and used to illustrate responses in some circumstances.

¹ Two Family Court judges responded to the survey regarding sentencing juveniles. These surveys were sent to Chief Judge Kuhn without any identifying information for her review and consideration.



Figure 8 presents a comparison of what judges indicate they need to determine substance abuse, and how often judges report they have that information at sentencing. Judges ranked the importance of the information they need on a scale of 1 to 12 and described the information they have in terms of a percentage of time it is available. Results from these questions were normalized in Base 10 so results could be compared.

Recommended Information System Goals

This report identifies some limitations regarding information related to offenders in treatment in Delaware. Following are recommendations that would improve Delaware’s ability to manage and evaluate treatment services for offenders. Many of these recommendations are intertwined, and some may be attainable through changes in current policies or practice.

- ❑ Establish a data warehouse of treatment and justice information that interfaces with existing data systems to house data that would enable tracking and analysis of offenders who have been ordered to, or have participated in, substance abuse treatment programs. The justice and treatment community need to agree on specific data requirements, and commit to data collection and sharing. An examination should be undertaken to determine if the COTS (Courts Organized to Serve, previously Commercial Off The Shelf) data system as proposed could provide this capacity.
- ❑ Establish mechanisms, policies, and/or practices to consistently identify conditions for substance abuse treatment, other services, and TASC in sentencing orders (currently some conditions appear in sentencing order text, some in notes, some appear as “previous conditions”). Improve the ability to differentiate “addiction” sentences (suspendable upon treatment completion) from other sentences with a condition for treatment. Ensure that all treatment ordered is captured, not just the initial treatment.
- ❑ Establish or improve the ability to track sentences to treatment and record dates of assessment, admission, services delivered, date of discharge, and discharge status *and* flag cases that are not progressing (e.g., who is waiting for assessment, who is waiting for admission).
- ❑ Improve information systems so that they capture all current activity from all courts, including pending charges and detainers.
- ❑ Improve mechanisms to provide assessment information at sentencing points, including violation of probation hearings. Capture prior treatment admissions, discharges and outcomes by dates so judges have a treatment history at sentencing.

- ❑ Provide aggregate summary assessment information (e.g., scores on the seven ASI domains) for research and system monitoring purposes. Information should be provided so that it can be merged with justice information.
- ❑ Provide judges and other justice and treatment professionals with standardized and regularly updated program names, descriptions, program capacity, availability, and waiting list information.
- ❑ Produce quarterly and annual reports on the numbers of offenders admitted, active in, and discharged from treatment, outcomes, and the facility, program, and/or supervision level in which the services were delivered.





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