Rapid #: -8237287

CROSS REF ID: **343891**

LENDER: **GZN :: Main Library**

BORROWER: **DLM :: Main Library**

TYPE:	Book Chapter
BOOK TITLE:	The effectiveness of innovative approaches in the treatment of drug abuse / edited by Frank M. Tims ... [et al.]
USER BOOK TITLE:	The Effectiveness of Innovative Approaches in the Treatment of Drug Abuse
CHAPTER TITLE:	CREST Outreach Center: A Model for Blending Treatment and Corrections
BOOK AUTHOR:	Lockwood, Inciardi, and Surratt
EDITION:	
VOLUME:	
PUBLISHER:	
YEAR:	1997
PAGES:	70-82
ISBN:	9780313300653
LCCN:	
OCLC #:	

PATRON: **Pugh, Brandie**

PATRON ID:	bpugh

Processed by RapidX: 8/4/2014 3:34:12 PM

24

Rapid #: -8237287

Odyssey
IP: 206.107.43.75/ILL

Status	Rapid Code	Branch Name	Start Date
New	DLM	Main Library	8/4/2014 12:22:27 PM
Pending	GZN	Main Library	8/4/2014 12:22:43 PM
Batch Not Printed	GZN	Main Library	8/4/2014 2:50:02 PM

CALL #: **RC564.65 .E36**
LOCATION: **GZN :: Main Library :: stacks**

TYPE: Book Chapter
BOOK TITLE: The effectiveness of innovative approaches in the treatment of drug abuse / edited by Frank M. Tims ... [et al.]
USER BOOK TITLE: The Effectiveness of Innovative Approaches in the Treatment of Drug Abuse
GZN CATALOG TITLE: The effectiveness of innovative approaches in the treatment of drug abuse /
CHAPTER TITLE: CREST Outreach Center: A Model for Blending Treatment and Corrections
BOOK AUTHOR: Lockwood, Inciardi, and Surratt
EDITION:
VOLUME:
PUBLISHER:
YEAR: 1997
PAGES: 70-82
ISBN: 9780313300653
LCCN:
OCLC #: GZN OCLC #: 34663280
CROSS REFERENCE ID: [TN:343891][ODYSSEY:206.107.43.75/ILL]
VERIFIED:

BORROWER: **DLM :: Main Library**
PATRON: **Pugh, Brandie**
PATRON ID: bpugh

RAPID ILL

5

CREST Outreach Center: A Model for Blending Treatment and Corrections

Dorothy Lockwood, James A. Inciardi, and Hilary L. Surratt

Since the mid-1980s, professionals from both treatment and corrections have been striving to combine their respective systems into a more effective model. Although compulsory treatment has been found effective (Anglin & Hser, 1991; Leukefeld & Tims, 1988), combining treatment and corrections has proven difficult for a variety of reasons. The primary problem has been the fundamental differences in the missions of treatment versus corrections. On the one hand, treatment aims to teach independence and self-sufficiency through increased skills and accountability. On the other hand, corrections is required to ensure punishment of the offender and safety for the community through control. Because of the dramatic increases over the past decade in the number of drug-involved offenders entering correctional settings, it has become necessary to develop effective drug treatment programs for criminal justice populations.

One of the more popular models for combining treatment and criminal justice has been the Treatment Alternatives to Street Crime (TASC) program, initiated by the Law Enforcement Assistance Administration in 1972 (Inciardi & McBride, 1991). However, most TASC programs have focused on nonincarcerated populations. As a result of the 1980s war on drugs, the nation's prisons quickly filled beyond capacity with drug-involved offenders. In fact, research shows that between 40 percent and 90 percent of arrestees test positive for drugs (Wish & Gropper, 1990) and that almost all imprisoned offenders are in need of drug treatment (Chaiken, 1989). In response, many correctional systems are now

structuring appropriate drug treatment programs for their growing populations.

In 1988, the Delaware Department of Corrections established the KEY, a therapeutic community (TC) program for male inmates with histories of serious drug involvement. The KEY was originally a 40-bed program, but in the years since its inception, its capacity has more than tripled. Participants in the KEY are segregated from the general prison population and are provided intensive treatment seven days a week. Clients remain in the program for six months to two years, depending on their sentence, release date, and need for further treatment. Regardless of length of stay, most clients' treatment addresses both their drug use and their criminal involvement. In addition, clients learn and adopt new prosocial coping and life skills.

As the first cohort of clients graduated from the KEY and returned to the free community, it became evident that a community-based transitional program was necessary to ensure that treatment continued, and that relapse or return to the institution did not occur (Inciardi, Martin, Lockwood, Hooper, & Wald, 1992). To fill this gap, during the closing months of 1990 the Center for Drug and Alcohol Studies at the University of Delaware was awarded a National Institute on Drug Abuse treatment demonstration grant to develop and evaluate the effectiveness of a co-ed, work-release TC. The Center for Drug and Alcohol Studies worked with state correctional officials, the program staff at the KEY, and university administrators to establish CREST Outreach Center, the nation's first work-release TC (Inciardi & Lockwood, 1994).

While the KEY represented "primary" treatment provided in the institution, CREST was developed as a "secondary" or "transitional" stage of TC treatment for men graduating from the KEY. At the same time, CREST intended to provide primary TC treatment for both men and women from the general prison population who had no previous TC experience.

THE RESEARCH PROTOCOL

Research participants were randomly assigned to either a treatment or a comparison group. The treatment group entered CREST Outreach Center and the comparison group was assigned to the traditional state-operated work-release center for prisoners. Participation was voluntary. Because all clients were incarcerated, they were protected under the special guidelines for prisoners as research subjects established by the U.S. Department of Health and Human Services. Under these regulations, neither correctional status nor court sentences may be affected — either positively or negatively — by participation in the research project. In addition, all respondents were protected by a Certificate of Confidentiality that ensured that the information they provided would not be given to

any authorities and that their participation in the research was confidential. Eligibility criteria for the study included a drug use history, work-release eligibility as defined by the Department of Corrections, and willingness to participate. Potential participants were identified by correctional counselors, prison release boards, and self-referral.

All respondents agreeing to participate in the study completed a baseline interview before leaving prison. The questionnaire was administered by a trained interviewer and assessed criminal history, drug use history, HIV risk behaviors (including needle use and sex practices), drug treatment experience, childhood experiences, mental health questions, and demographic information. Respondents were also asked to provide a urine sample for drug testing and a blood sample for HIV and hepatitis testing, however participation in the testing was voluntary. In addition, two follow-up interviews were conducted at 6 and 18 months after the baseline interview. The first follow-up interview corresponded with either the completion of work release or the CREST program, depending on research group assignment. Both follow-up interviews focused on criminal activity, drug use, drug treatment experience, HIV risk behaviors, and mental health status in the time period since the most recent interview.

CREST OUTREACH CENTER

CREST is a six-month program based on the traditional TC model, modified to serve a correctional population. It is a 60-bed program serving 12 women and 48 men, a segment of whom are graduates of the KEY. CREST is adjacent to the state-operated work-release center, and correctional officers at the work-release center also provide security to CREST. In these settings, security measures include monitoring the comings and goings of every CREST client, conducting head counts to ensure that all clients are accounted for, and securing the building at night. CREST clients spend from 7 a.m. until 10:30 p.m. in the treatment facility, returning to the work-release facility only to shower and sleep. Although CREST is adjacent to the work-release center, CREST sleeping quarters are completely separate from the other work-release quarters and clients from the two programs do not interact.

CREST was founded on a traditional TC philosophy. Drug use is considered to be a symptom of a wider behavioral disorder. As such, the reduction or elimination of drug use requires that the whole person be treated. Other symptoms of dysfunctional thinking and living are also addressed — including criminal activity and interpersonal relationships. The goal of CREST is to effect positive lifestyle changes by addressing attitudes, thoughts, and behaviors. Treatment encompasses a variety of interventions in which accountability for one's actions and attitudes,

coupled with role modeling and increased responsibility, are emphasized (Hooper, Lockwood, & Inciardi, 1993).

CREST Outreach Center is a highly structured program of treatment activities that consists of five phases. The program begins with a two-week orientation period involving client assessment and evaluation, as well as an introduction to the TC process. During the second phase, clients begin to participate in treatment activities, such as morning meetings, community jobs, and group and individual counseling. After clients learn to negotiate the TC environment successfully, they move to the third phase of the program in which they begin to take on more responsibilities, such as role modeling and supervision of other clients. During the fourth phase, clients begin the process of transition to the community by working on job-seeking skills, preparing resumes, and practicing job interviewing. The fifth phase of treatment is reentry into the community. It is in this phase that clients maintain steady and acceptable employment in the community and develop an aftercare plan for continued treatment and support, including seeking an appropriate and supportive living situation. During the first three months of treatment, clients remain in the program and are not employed outside of CREST. The final three months of the program focus on transition to the community, including the development of employment skills and the establishment of support systems. During this transition phase, clients remain at CREST and participate in treatment activities when they are not working (Lockwood, 1992; Lockwood & Inciardi, 1993).

All clients, regardless of previous treatment experience, participate in all five phases. Graduates of the KEY, because of their previous TC treatment, serve as role models throughout the program. Many of the KEY clients advance quickly through the program and enter the work-release phase sooner than clients entering the program from the general prison population. Release from CREST depends on progress through the treatment program, as well as completion of the correctional sentence. Many clients progress through treatment and are ready to transition into the community before the completion of their sentence. In these cases, CREST staff work closely with correctional staff and court officials to modify sentences appropriately so that client progress does not deteriorate.

As in most TCs, CREST clients run the program, ensuring that house jobs are completed, that treatment activities are implemented, and that their peers are participating fully in the program. Each client has a job responsibility within the program. Job assignments change regularly so that all clients can be exposed to the various positions necessary to operate the program. Clients who have shown the greatest progress and growth hold positions of authority within CREST, such as facility manager. CREST staff includes both professionals and recovering persons. Staff

facilitates treatment activities and monitors client progress and participation. Staff also provides both individual and family counseling.

FINDINGS

The effectiveness of CREST Outreach Center can best be evaluated by two factors. First, the number of clients completing the program and remaining drug- and crime-free indicates, in part, to what extent the program successfully provided drug treatment to its clients. Second, comparison of the status of CREST clients to a comparable group who did not participate in CREST indicates, in part, whether CREST is more effective than other programs, in this case traditional work-release.

The research design targeted 260 respondents in each of the two groups, treatment and comparison. The treatment group consisted of 288 respondents and the comparison group included 246 respondents for a total of 534 respondents. For the purposes of data presentation, three groups will be discussed:

the KEY-CREST group includes those who received primary TC treatment at the KEY program and secondary treatment at CREST;

the CREST group includes those who received primary treatment at CREST; and

the Comparison group includes respondents who participated in the regular work-release program and did not receive TC treatment.

This grouping allows for the comparison of the effectiveness of CREST with traditional work-release, as well as the examination of the outcome differences between CREST clients receiving secondary treatment and those receiving prior treatment.

Table 5.1 provides an overview of the descriptive characteristics of the study respondents. Because one purpose of the study was to test the effectiveness of a work-release TC for inmates, it was important that the research sample be representative of the general prison population. The Delaware prison population is approximately 58 percent African-American, 34 percent white-Anglo, with the remaining 8 percent classified as other. The total study sample is approximately 70 percent African-American, 25 percent white-Anglo, 3 percent Hispanic, and 2 percent other. As such, African-Americans are slightly overrepresented in the study sample. Additionally, the Delaware prison population is about 80 percent male and 20 percent female, and the study sample is comparable with 82 percent male and 18 percent female participants.

To evaluate the effectiveness of CREST as compared with traditional work release, it was important that participants in each group be similar on measures of sociodemographic characteristics, and criminal, drug use, and treatment histories. Because membership in the KEY-CREST group

TABLE 5.1
Descriptive Characteristics of Research Respondents

Variable	CREST (N = 246)		KEY-CREST (N = 42)		Comparison (N = 246)		Total (N = 534)	
	N	%	N	%	N	%	N	%
RACE/ETHNICITY								
Black	172	69.9	39	92.9	164	66.7	375	70.2
Hispanic	7	2.8	1	2.4	7	2.8	15	2.8
White-Anglo	65	26.4	2	4.8	67	27.2	134	25.1
Other	2	.8	1	2.4	8	3.3	10	1.9
GENDER								
Female	50	20.3	—	—	46	18.7	96	18.0
Male	196	79.7	42	100.0	200	81.3	438	82.0
AGE								
Range	18 to 52		20 to 48		18 to 53		18 to 53	
Average	29.4 years		30.3 years		29.9 years		29.7 years	
CRIMINAL HISTORY								
Previous Times in Prison:								
0 (First Incarceration)	76	30.9	10	23.8	71	28.9	157	29.4
1–2	99	40.2	20	47.6	93	37.8	212	39.7
3–5	59	24.0	11	26.2	67	27.2	137	25.7
6 or more	12	4.9	1	2.4	15	6.1	28	5.2
Previous Conviction for:								
Violent crimes	140	56.9	29	69.0	141	57.3	310	58.1
Property crimes	197	80.1	32	76.2	185	75.2	414	77.5
Drug crimes	166	67.5	30	71.4	156	63.4	352	65.9
DRUG USE AND PRIMARY DRUG OF ABUSE								
None	4	1.6	1	2.4	29	11.8	34	6.4
Alcohol	28	11.4	1	2.4	39	15.9	68	12.7
Marijuana	23	9.3	6	14.3	34	13.8	63	11.8
Cocaine	105	42.7	24	57.1	91	37.0	226	41.2
Crack	38	15.4	2	4.8	18	7.3	58	10.9
Heroin	44	17.9	7	16.7	25	10.2	76	14.2
Other	4	1.6	1	2.4	10	4.1	15	2.8
PREVIOUS TREATMENT								
	195	79.3	42	100.0	177	72.0	414	77.5

was determined by participation in the in-prison TC, and because KEY clients were selected by a different process than the other study participants, the KEY-CREST client group was not included in the comparison of the treatment and traditional work-release groups. Respondents in the CREST and comparison groups were similar in terms of sociodemographic characteristics. The CREST group was approximately 70 percent African-American, whereas the comparison group was approximately 67 percent African-American. Both groups were 2.8 percent Hispanic and approximately 27 percent white-Anglo. The average age of respondents in both groups was about 30 years, ranging from 18 to 53 years.

Importantly, both the CREST and comparison groups were similar with respect to respondents' criminal histories. More than two-thirds of the respondents in both the CREST and comparison groups had been in prison prior to the sentence they were currently serving when recruited into the research project. Almost 60 percent of the respondents in both groups had been convicted of a violent crime. Three-fourths of the respondents in the comparison group had been convicted of a property crime, as had 80 percent of respondents in the CREST group. A slightly higher proportion of the CREST group had been convicted of drug offenses (67.5 percent) than in the comparison group (63.4 percent).

At baseline, the CREST group reported a more serious drug use history than did the comparison group. Only four of the CREST group respondents reported no previous drug use problems, whereas 29 respondents, almost 12 percent of those in the comparison group, reported no drug problems. Additionally, a greater proportion of the CREST group indicated that crack, cocaine, or heroin was their primary drug of abuse than did respondents in the comparison group. With respect to previous drug treatment, more of the CREST group had been in treatment than had the comparison group, 79.3 percent and 72 percent, respectively.

The KEY-CREST group represented a slightly different population than did the CREST and comparison groups. All the respondents in the KEY-CREST group were males, 92.9 percent of whom were African-American. These respondents were slightly older than respondents in the other two groups, although the average age was also 30 years. Over three-fourths of the respondents in this group had been in prison prior to their current sentence. In addition, almost 70 percent had previously been convicted of a violent crime, 76 percent of a property crime, and 71 percent of a drug crime. Only one respondent reported no previous drug problem, while almost 60 percent and 17 percent, respectively, reported a history of cocaine and heroin use. By virtue of their participation in the KEY, all respondents in this group had had previous drug treatment experience. In summary, the KEY-CREST group was comprised of respondents with more serious criminal and drug use histories.

The preliminary follow-up data indicate that the CREST and KEY-CREST group respondents reported much lower incidences of criminal activity and drug use at the six-month follow-up than did the comparison group respondents. Of respondents from the KEY-CREST and CREST groups, 96 percent and 83 percent, respectively, remained arrest-free during the six-month period. However, only 71 percent of the comparison group had not been rearrested during the six-month period. A more stringent measure of criminal activity indicated an even stronger difference between the treatment and comparison groups. When respondents were asked if they had committed any crimes since the baseline interview, including those for which they were not arrested, 85 percent of the CREST group reported being crime-free, 97 percent of the KEY-CREST group reported no crime involvement, but only 51 percent of the comparison group reported no criminal activity. In other words, almost half of the respondents who did not receive TC treatment returned to crime within six months of release whereas only 14 percent of the respondents who received TC treatment returned to crime in the same period.

Drug use during the six-month follow-up period parallels the pattern of criminal involvement. Only 20 percent of the CREST clients and 6 percent of the KEY-CREST clients reported relapse to drug use during the six-month period. However, 45 percent of the comparison group respondents reported drug use in this period. The respondents in the CREST group who relapsed reported use of alcohol or marijuana. However, among the comparison group, respondents reported relapse to use of alcohol, marijuana, crack, and cocaine. Not only did a higher proportion of the comparison group return to drug use within six months of release from prison, they also returned to more serious drug use. In summary, 94 percent of the KEY-CREST clients and 80 percent of CREST clients remained drug-free after six months, while only 55 percent of the comparison group clients did so.

Clearly, both KEY-CREST and CREST clients reported better maintenance of drug-free and crime-free behaviors than did the comparison group clients. From this preliminary analysis, it appears that CREST, a work-release TC, is effective in reducing both criminal activity and drug use. When compared with a group similar on measures of sociodemographic status, criminal history, and drug use history who participated in a traditional work-release program, CREST clients had a significantly lower incidence of both criminal activity and drug use during the first six-month period after release. These differences have major implications for the fields of drug treatment and corrections.

First, it appears that treatment and corrections can be successfully combined in a mutually effective model. Reaching a balance between increased client responsibility and continued surveillance is a matter of coordination and cooperation. However, the TC model provides an

excellent framework in which to strike this balance. The TC is structured so that both the time and activities of every client are planned and structured during the first three months of the program and are closely monitored throughout. This structure complements correctional surveillance and ensures that clients are held accountable. It is only after clients have learned and adopted prosocial behaviors that their independence and responsibilities are increased.

In fact, because clients are monitored so closely, approximately one-fourth of new admissions are returned to prison as a result of their violation of program rules. The ability of the TC structure to detect this reluctance to make positive changes in attitudes and lifestyles in the long run lowers the risk of recidivism and relapse. As such, the structure of the TC complements the correctional priority of identifying high-risk offenders and delaying their release into the community until the risk has been decreased.

The philosophy of the TC, which emphasizes treatment of the whole person, is another factor that increases the ease with which corrections and treatment can be combined. The outcome data indicate that not only is relapse to drug use reduced among CREST clients but also recidivism to criminal activity is similarly reduced. Interestingly, among the comparison group respondents who participated in the correctional work-release program, there was a high incidence of both relapse and recidivism. It appears that the TC work-release model, which treats the whole person by teaching coping and life skills, in addition to providing drug treatment, may be more effective in reducing criminal activity than the corrections-based program. From these analyses, it is clear that the TC structure is compatible with the correctional priorities of reducing recidivism to criminal activity.

Although TC treatment and corrections can be interfaced, coordination between the two systems is a necessity. The most obvious and important point of coordination is with regard to clients' correctional sentences. CREST clients' sentences vary greatly. Some clients have sentences prescribing a specific amount of time to be served, while others are sentenced until the completion of drug treatment. At CREST, as with any TC, progression through the phases of treatment is determined by the client's actions and attitudes and not by a prescribed length of time. One of the first lessons learned by clients in a TC program for criminal justice is that they are not serving time; treatment completion is not determined by a certain number of months but rather by progress and positive change. The correctional system and the courts must work with the treatment program to support this mode of completion. Frequently, clients complete treatment prior to their sentence release date. It is essential that clients are able to progress through treatment because stagnation at any phase tends to result in regression and noncompliance. CREST was quite successful in

gaining the cooperation and support of the courts to reduce client sentences based on progress in treatment. Although completion of court sentences may appear to be incompatible with treatment progression, the experience at CREST proves that the two can be effectively combined.

Another point of coordination for the drug treatment and correctional systems is the determination of who has primary responsibility for the clients. CREST clients are under the custody of the Department of Corrections, which provides continuous monitoring and places priority on monitoring over and above all other activities. However, this arrangement frequently results in surveillance activities overriding the treatment process. Thus, to avoid the interruption of treatment activities, the TC program must act as the primary source of client accountability. In practice, this does not undermine or replace the surveillance responsibility of corrections. In fact, the structure and intensity of CREST, or any TC, inherently provides the monitoring and accountability necessary to fulfill the surveillance obligations of corrections.

The second major implication of this study is that compulsory drug treatment works. Although research has shown that compulsory treatment is successful (Leukefeld & Tims, 1988), an assumption prevails that successful treatment outcomes depend on motivation to seek treatment. However, the desire for treatment is not incompatible with participation in court-ordered treatment. Almost all of the CREST clients were required to complete drug treatment as a stipulation of their court sentence, yet they also volunteered to participate in CREST. Three-fourths of those choosing to go to CREST remained in the program and the overwhelming majority remained drug-free and crime-free. This suggests that compulsory treatment does work.

Compulsory treatment also provides an assurance that clients remain in treatment long enough for it to have a positive effect. In the case of CREST clients, a decision to leave treatment before completion results in return to prison. This lack of desirable options serves as an impetus for clients to remain in treatment. The drug-free and crime-free status of CREST clients indicates that remaining in treatment has a positive effect.

The TC model is an effective mechanism to impose compulsory treatment. Unlike some drug treatment modalities, it is impossible to complete TC treatment without engaging in the process and progressing. Again, the structure and intensity of the CREST program requires clients to work and become involved in their own treatment. Lack of participation and positive change results in removal from the program. As such, TC clients cannot slide through the program or in prison argot "just do time."

The final implication of this study is that a continuum of drug treatment is most effective. It is evident that the CREST clients had a lower incidence of relapse and recidivism than the respondents who did not receive TC treatment. It is also evident that clients receiving a continuum

of treatment, beginning with primary treatment in prison followed by secondary treatment in the work-release setting, are less likely to relapse to drug use and return to criminal activity than the clients who received only primary TC treatment in the work-release setting.

Primary treatment in an in-prison TC also reduces the discharge rate prior to completion of the TC work-release program. About one-fourth of the CREST clients from the general prison population who had not received primary TC treatment were returned to prison before completion of CREST. However, less than 10 percent of the KEY-CREST clients failed to complete the program. Considering that, on average, the KEY-CREST clients had more extensive criminal and drug use histories, the continuum of TC treatment may be necessary for successful outcomes among the more crime- and drug-involved clients.

IMPLICATIONS

The preliminary analyses presented here indicate that TC treatment is more effective in reducing recidivism and relapse to drug use than the traditional corrections-based work-release program. Furthermore, the continuum of TC treatment appears to be most effective. The findings from this research also show that treatment and corrections can be combined and that compulsory treatment works. Thus, this research provides a tested, effective model of drug treatment for criminal justice clients. Correctional clients differ from noncriminal justice clients in that criminal justice clients must satisfy legal obligations in conjunction with treatment. In addition, they present other specific treatment needs primarily because of their criminal activity. As such, drug treatment must address the legal needs and criminal involvement of criminal justice clients. The TC offers the framework for such a drug treatment program.

The findings from this research indicate that the TC model blends corrections and treatment in an effective form to serve criminal justice clients. The structure and intensity of the TC model ensure the surveillance and monitoring necessary for criminal justice clients. In addition, the TC philosophy of treating the whole person to effect positive lifestyle changes encompasses the need to address the criminal involvement as well as the drug use of clients. The TC model allows for involvement of other organizations in ensuring appropriate treatment for criminal justice clients, such as TASC. As previously discussed, coordinating sentence completion and treatment completion is a fundamental consideration when serving criminal justice clients. On the surface, coordinating sentence and treatment completion may seem incompatible, but the experience at CREST shows that it can be accomplished. TASC case managers could serve an important role as liaison between treatment and the courts to ensure that both requirements are satisfied.

Additional findings of this study also underscore the importance and necessity of conducting research on treatment programs. Without the research component of this project, comparison data would not be available. TC treatment is expensive; however, the data provided by this research indicate that those additional costs may be justified in the long term. Intense, costly treatment at the onset may reduce costs of continued, future reincarceration. As prison populations and the cost of incarceration continue to rise, implementing programs to reduce recidivism must be a priority among criminal justice officials. Ensuring that more costly programs are also more effective is also a priority. This can only be accomplished through treatment research.

The final implication of the findings is the continued need for aftercare. The success of the KEY-CREST clients indicates the effectiveness of a continuum of treatment. However, this continuum represents only two stages. Aftercare, the final stage of the continuum, is necessary to assist clients as they return and adjust to the community. Data from the second follow-up interview will indicate the degree to which CREST clients remain crime-free and drug-free during the first year after treatment. Regardless of the outcome, aftercare must be seen as an essential component in the maintenance of a drug-free, crime-free lifestyle.

REFERENCES

Anglin, M. D., & Yih-Ing Hser. (1991). Criminal justice and the drug-abusing offender: Policy issues of coerced treatment. *Behavioral Sciences and the Law, 9,* 243–267.

Chaiken, M. R. (1989). *In-prison programs for drug-involved offenders.* Washington, DC: National Institute of Justice.

Hooper, R. M., Lockwood, D., & Inciardi, J. A. (1993). Treatment techniques in corrections-based therapeutic community. *The Prison Journal, 73*(3–4), 290–306.

Inciardi, J. A., & Lockwood, D. (1994). When worlds collide: Establishing CREST outreach center. In B. W. Fletcher, J. A. Inciardi, & A. M. Horton (Eds.), *Drug abuse treatment: The implementation of innovative approaches* (pp. 63–78). Westport, CT: Greenwood Press.

Inciardi, J. A., Martin, S. S., Lockwood, D., Hooper, R. M., & Wald, B. M. (1992). Obstacles to the implementation and evaluation of drug treatment programs in correctional settings: Reviewing the Delaware KEY experience. In C. G. Leukefeld & F. M. Tims (Eds.), *Drug abuse treatment in prisons and jails* (pp. 176–191). Rockville, MD: National Institute on Drug Abuse.

Inciardi, J. A., & McBride, D. C. (1991). *Treatment alternatives to street crime: History, experiences and issues.* Rockville, MD: National Institute on Drug Abuse.

Leukefeld, C. G., & Tims, F. M. (Eds.). (1988). *Compulsory treatment of drug abuse: Research and clinical practice.* Rockville, MD: National Institute on Drug Abuse.

Lockwood, D., & Inciardi, J. A. (1993). CREST outreach center: A work release iteration of the TC model. In J. A. Inciardi, F. M. Tims & B. W. Fletcher (Eds.),

Innovative approaches in the treatment of drug abuse (pp. 61–70). Westport, CT: Greenwood Press.

Lockwood, D. (1992, March 10–14). Modeling a modified TC design for work release. Paper presented at the annual meeting of the Academy of Criminal Justice Sciences, Pittsburgh, Pennsylvania.

Wish E. D., & Gropper, B. A. (1990). Drug testing by the criminal justice system: Method, research and applications. In M. Tonry & J. Q. Wilson (Eds.), *Drugs and crime* (pp. 321–390). Chicago, IL: University of Chicago Press.