The Assaultive Offender Program – a current report

The good news is that the MDOC has made substantial improvements in the delivery of assaultive offender programming. The bad news is that significant problems remain.

The Assaultive Offender Program (AOP) is group therapy that typically takes 10-12 months. While successfully completing the program by no means guarantees that parole will be granted, the parole board often uses non-completion as a reason for denying release.

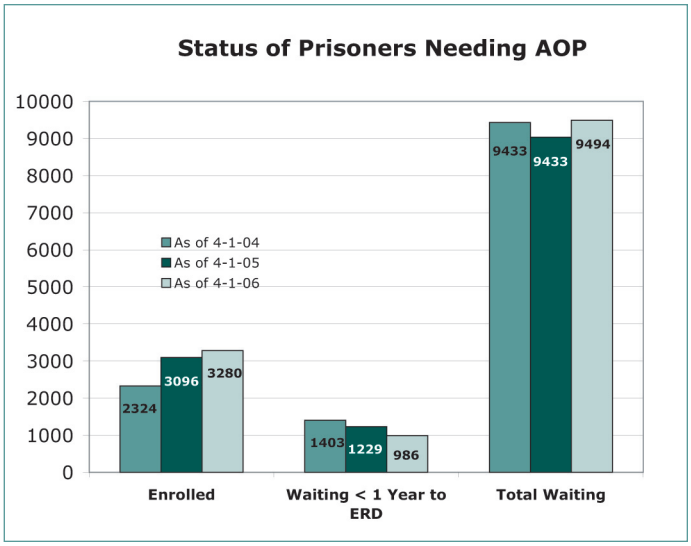
A report issued by CAPPS and the American Friends Service Committee (AFSC) in April 2005 explained that hundreds of people who had served their minimum sentences were routinely denied parole because they could not gain access to treatment that costs about $1,400 per prisoner. (See *Penny-wise and Pound-Foolish, Assaultive offender programming and Michigan's prison costs, www.capps-mi.org/publications)* On April 1, 2004, waiting lists for AOP contained 1,430 people who were within one year of or had already passed their earliest release date (ERD). Enrollment in AOP was 2,324.

The MDOC began increasing AOP enrollment while the CAPPS/AFSC report was being prepared. After it was published, the legislature placed language in the corrections appropriations bill for 2006 requiring the MDOC to maintain a statewide waiting list for AOP (instead of separate lists for each facility) and to transfer people, when necessary and possible, to enable them to enter AOP groups. The same language appears in the 2007 budget bill.

The MDOC has implemented a statewide list, begun transferring people as treatment openings occur, hired additional therapists and instituted some management changes. Nearly 500 more people were admitted to AOP from May 1, 2005 – April 1, 2006 than during the preceding 12-month period, a gain of nearly 22 percent.

As the graph shows, between April 1, 2004 and April 1, 2006, enrollment in AOP increased by 41 percent. The number of people who are past or within a year of their earliest release date has decreased by 30 percent.

Despite this substantial progress, however, nearly 1,000 people remain on the waiting list who will not have the opportunity to complete AOP before serving their minimum sentences. Most will be denied parole. In addition, many people currently enrolled in therapy did not enter in time to complete it before their ERD and will have their parole decisions deferred for months as a result. And the waiting list for people who are more than a year from their first release date is actually larger than ever. MDOC data does not break down just how far from their ERD these people are, making it difficult to plan adequately for the future.



CAPPS and AFSC continue to receive correspondence weekly on AOP-related issues. In the last eight months, AFSC has contacted the Psychological Services Unit (PSU) regarding problems with AOP more than 50 times.

Some of the letters demonstrate how difficult it still can be to access the program. Willie Gaines, who was convicted of armed robbery in 1996, first became eligible for parole in April 2006. The Reception and Guidance Center did not recommend AOP when Gaines entered prison. However, having heard about people serving for robbery who were denied parole for lack of AOP, Gaines began seeking entry to the program in 2003. He was assessed and put on a waiting list in 2004. In April 2005, he was transferred to the Cooper Street Facility, ostensibly so he could enter AOP. That didn't happen, however, and in July he was transferred to a camp where AOP was not offered. In November he was transferred to a camp that had the program, but he was not admitted to it until May 2006, one

month after his earliest release date.

Other complaints address different concerns. Quite common is the manner in which people are whipsawed between the assessments of therapists and the demands of the parole board. People may be screened out of AOP by PSU staff because they have shown no pattern of assaultive behavior or because their crime does not meet established criteria for participation. However, when the parole board interviews them, release is often denied because the board thinks they should "be screened for AOP." The clear message is that the board disagrees with the therapist's judgment and will not grant parole unless AOP is completed. If the therapist continues to deny admission, there is nothing the prisoner can do. Even if admission to AOP is permitted in order to satisfy the board, the person will have served an extra year, at least.

Keith Laney's situation exemplifies this problem. Laney was sentenced in 2002 for two counts of larceny from a person, an offense that did not qualify him for AOP. After twice trying unsuccessfully to enter the program, in June 2003 Laney filed a grievance explaining that he had been the driver in two armed robberies and the original charges had been bargained down.

Laney's earliest release date was not until April 2006, but he wrote in his grievance: *I do not want to get flopped by the Parole Board for not being involved in this program…I want to be absolutely certain they won't tell me I need this program when it's too late for me to complete it*. The response to his grievance was that he did not meet the criteria for admission.

Three years later, in March 2006, Laney received a 12-month continuance from the parole board. It stated as a reason for parole denial: "Needs AOP or RSAT [residential substance abuse treatment]. When PSU reiterated its position that Laney's crimes did not fit the criteria for AOP, he filed another grievance, stating: *This is my fourth attempt to take [AOP]. The Parole Board recommended the class and the psychologists will not allow me to participate. What am I supposed to do?*

Laney was finally admitted to therapy in May 2006 and is now scheduled to complete it in May 2007, 13 months after he first became eligible for parole.

Overall, from May 2005 – April 2006, the number of people denied admission to AOP fell by 60 percent over the preceding 12 months, from 947 to 378. This occurred in large measure because PSU lowered the threshold for admission. In particular, people who deny that they are assaultive may now be admitted. To the extent that people who need therapy are being screened in, this is an important step. If, however, people who are not truly assaultive are being pushed through therapy based on arbitrary criteria set by the parole board, resources are being wasted.

The number of people completing therapy during the 2005-06 period rose by 42 percent. However, another trend raises concern. The number of people terminated from the program without completion increased by 41 percent. Data does not exist to explain the basis for these terminations.

Disagreement between therapists and the parole board at the other end of the process also remains common. People with positive AOP completion reports, favorable parole guidelines scores and a history of good institutional conduct are routinely denied release because the board perceives them to be a risk to public safety, based on their original offense, or feels after a brief interview that they "lack insight."

No data is kept on the how disagreements between psychological services and the parole board affect release.

Other issues that result from the tension between treatment needs and custody concerns also remain. For instance, at prisons that have security levels 1 and 2, the warden decides whether AOP groups can mix prisoners from both levels. This may affect whether people housed at level 2 can get into a group that has openings at their own facility.

AOP is still not provided at levels 3, 4 and 5. Thus, higher security prisoners, who may need therapy the most, do not receive it. Some discharge to the community after serving their maximum sentences without parole supervision and without having had AOP.

While the MDOC has made real progress in decreasing the waiting list for assaultive offender therapy, hundreds of people will still be denied parole, wasting millions of taxpayer dollars, because they could not access a required treatment program in time. Even more fundamentally, questions remain about whether people are receiving the amount of therapy that is appropriate to their individual circumstances and about what role the assessments of the MDOC's own psychologists should play in determining a person's suitability for release.