DRUG TREATMENT PROGRAMS AND THE CRIMINAL JUSTICE SYSTEM: MAKING TREATMENT WORK

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

JULY 22, 1998

Serial No. 105–204

Printed for the use of the Committee on Government Reform and Oversight

U.S. GOVERNMENT PRINTING OFFICE

55–871 WASHINGTON : 1999

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-058579-1

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

DAN BURTON, Indiana, *Chairman*

BENJAMIN A. GILMAN, New York
J DENNIS HASTERT, Illinois
CONSTANCE A. MORELLA, Maryland
CHRISTOPHER SHAYS, Connecticut
CHRISTOPHER COX, California
ILEANA ROS-LEHTINEN, Florida
JOHN M. McHUGH, New York
STEPHEN HORN, California
JOHN L. MICA, Florida
THOMAS M. DAVIS, Virginia
DAVID M. McINTOSH, Indiana
MARK E. SOUDER, Indiana
JOE SCARBOROUGH, Florida
JOHN B. SHADEGG, Arizona
STEVEN C. LATOURETTE, Ohio
MARSHALL "MARK" SANFORD, South Carolina
JOHN E. SUNUNU, New Hampshire
PETE SESSIONS, Texas
MICHAEL PAPPAS, New Jersey
VINCE SNOWBARGER, Kansas
BOB BARR, Georgia
DAN MILLER, Florida
RON LEWIS, Kentucky

HENRY A. WAXMAN, California
TOM LANTOS, California
ROBERT E. WISE, JR., West Virginia
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
PAUL E. KANJORSKI, Pennsylvania
GARY A. CONDIT, California
CAROLYN B. MALONEY, New York
THOMAS M. BARRETT, Wisconsin
ELEANOR HOLMES NORTON, Washington, DC
CHAKA FATTAH, Pennsylvania
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
ROD R. BLAGOJEVICH, Illinois
DANNY K. DAVIS, Illinois
JOHN F. TIERNEY, Massachusetts
JIM TURNER, Texas
THOMAS H. ALLEN, Maine
HAROLD E. FORD, JR., Tennessee

BERNARD SANDERS, Vermont (Independent)

KEVIN BINGER, *Staff Director*
DANIEL R. MOLL, *Deputy Staff Director*
DAVID A. KASS, *Deputy Counsel and Parliamentarian*
JUDITH MCCOY, *Chief Clerk*
PHIL SCHILIRO, *Minority Staff Director*

SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

J. DENNIS HASTERT, *Chairman*

MARK E. SOUDER, Indiana
CHRISTOPHER SHAYS, Connecticut
ILEANA ROS-LEHTINEN, Florida
JOHN M. McHUGH, New York
JOHN L. MICA, Florida
JOHN B. SHADEGG, Arizona
STEVEN C. LATOURETTE, Ohio
BOB BARR, Georgia

THOMAS M. BARRETT, Wisconsin
TOM LANTOS, California
ROBERT E. WISE, JR., West Virginia
GARY A. CONDIT, California
ROD R. BLAGOJEVICH, Illinois
JIM TURNER, Texas
ELIJAH E. CUMMINGS, Maryland
JOHN F. TIERNEY, Massachusetts

EX OFFICIO

DAN BURTON, Indiana
HENRY A. WAXMAN, California

ROBERT CHARLES, *Staff Director and Chief Counsel*
DALE ANDERSON, *Senior Investigative counsel*
AMY DAVENPORT, *Clerk*
MICHAEL YEAGER, *Minority Counsel*

CONTENTS

Page

Hearing held on July 22, 1998 1

Statement of:

Hill, Bryan, president, American Jail Association, warden, Monroe County Correctional Facility; Arthur Pratt, president, Life Effectiveness Training; Douglas Lipton, Ph.D., senior research fellow, National Development & Research Institute; and Faye Taxman, Ph.D., associate research professor, University of Maryland 138

Vereen, Donald, M.D., Deputy Director, Office of National Drug Control Policy; Marsha Lillie-Blanton, Associate Director, General Accounting Office; Sally Satel, M.D., psychiatrist, Oasis Clinic; Eric Wish, Director, Center for Substance Abuse; and Raymond Soucek, president, Haymarket Center 7

Letters, statements, etc., submitted for the record by:

Barrett, Hon. Thomas M., a Representative in Congress from the State of Wisconsin, prepared statement of 4

Hill, Bryan, president, American Jail Association, warden, Monroe County Correctional Facility, prepared statement of 141

Lillie-Blanton, Marsha, Associate Director, General Accounting Office, prepared statement of 25

Pratt, Arthur, president, Life Effectiveness Training, prepared statement of 154

Satel, Sally, M.D., psychiatrist, Oasis Clinic, prepared statement of 36

Soucek, Raymond, president, Haymarket Center, prepared statement of .. 63

Taxman, Faye, Ph.D., associate research professor, University of Maryland, prepared statement of 167

Vereen, Donald, M.D., Deputy Director, Office of National Drug Control Policy, prepared statement of 10

Wish, Eric, Director, Center for Substance Abuse, prepared statement of 49

DRUG TREATMENT PROGRAMS AND THE CRIMINAL JUSTICE SYSTEM: MAKING TREATMENT WORK

WEDNESDAY, JULY 22, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY,
INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:11 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (acting chairman of the subcommittee) presiding.

Present: Representatives Souder, Mica, Barr, Barrett, and Turner.

Staff present: Robert Charles, staff director and chief counsel; Dale Anderson, senior investigative counsel; Amy Davenport, clerk; Michael Yeager, minority counsel; and Amy Wendt, minority staff assistant.

Mr. MICA. Good morning. I would like to call this meeting of the Subcommittee on National Security, International Affairs, and Criminal Justice to order. Good morning, everyone. Thank you for coming. I apologize for the delay in getting started this morning, but this is an important hearing and I appreciate your attendance.

This is the latest in a series of hearings on drug treatment and drug testing. Today, we will hear from two distinguished panels of experts in drug treatment. We will also hear some contrary points of view. Accountability in this area is extremely vital, and that is why we are searching as a congressional committee, through this hearing and other hearings, for the most effective type of drug treatment. We need to know exactly what works and what doesn't work.

Initially, let me say that we spend in excess of $3 billion Federal tax dollars on drug treatment annually. It is an astounding amount. In that context, we hear a lot of statistics about drug treatment and its effectiveness.

For that reason, the Speaker of the House and many of us in Congress have joined in a bipartisan request that the General Accounting Office determine where Federal dollars are being spent and whether those dollars, in fact, are being spent effectively. We have now received the GAO's report, and we will hear testimony about this report.

In addition to GAO, on the first panel, we will also hear from Dr. Donald Vereen, General McCaffrey's deputy; Dr. Marsha Lillie-

Blanton, a drug treatment expert; Dr. Sally Satel, a clinician who will explain to us from firsthand experience how the war should be fought; Dr. Eric Wish, a researcher with a broad range of experience in the community of treatment scholars will also join us; and Mr. Ray Soucek, president of Haymarket. He will explain drug treatment process and the role of spirituality in the recovery process.

The second panel today has been assembled to explain more specific aspects of the treatment problem. Mr. Bryan Hill and Mr. Arthur Pratt will discuss treatment from the perspective of correctional facilities. Dr. Douglas Lipton and Dr. Faye Taxman will conclude by sharing with us their expertise on treatment within the broader criminal justice system. This is an arena where there is consensus on at least one issue: No one is for addiction. This issue rises above party, above partisan politics or above ideology. What we are trying to do here is to truly identify where we should channel our precious and sometimes limited Federal funds in an effort to successfully treat addicts. If we all listen to these witnesses with open minds, I think we can all come away with ideas that hopefully will make a big difference.

Personally, I think this is one of the most important hearings this Congress will face because drug addiction and the problem of illegal narcotics and narcotics use among our population, as we know, has escalated. Our prisons are filled to the brim, we have over 2 million people behind bars. My local sheriff, in a hearing we held in my county, testified that 70 percent of the people behind his prison walls who are in State prisons, that he sent to our State facilities, are there because of drug problems or drug crimes or drug addiction. This is an incredible problem.

The other thing that personally concerns me is the addiction level and increased drug use by our young people, and there is nothing that will tear at your heart strings more than to hear of a parent who has a young son or daughter who is addicted to narcotics and they have tried the various treatment programs and nothing succeeds.

We have been fortunate in central Florida to have some faith-based programs that have been very successful, a 90-percent success rate. When we spend billions of Federal tax dollars on treatment programs that are not effective, we have a very serious problem; and we also have hundreds of thousands of parents who are at wit's end trying to resolve their personal problems with youth that have gone astray and they can't find treatment that works. So this, indeed, is a very important hearing for the Congress and for those parents and for the future of those young people who have fallen into addiction.

I am now pleased to recognize the ranking member of this panel, the distinguished gentleman, my colleague, Mr. Barrett, for his opening statement.

Mr. BARRETT. Thank you, Mr. Chairman, and good morning to our panels of witnesses. This hearing will focus on the effectiveness of drug treatment programs, particularly in the criminal justice system, and the potential treatment to combat drug abuse and all of its attendant social problems: crime, health care costs, social welfare costs, and lost productivity.

In January, the National Center on Addiction and Substance Abuse at Columbia University released a comprehensive study on the relationship between drug abuse and the growing prison population in our country. According to the study, the prison population in Federal and State systems has exploded over the past two decades. Between 1980 and 1996, the number of inmates in the United States more than tripled, from roughly 500,000 people to more than 1.7 million. Drug abuse accounts for the lion's share of this increase.

In the State prison system, convictions for drug violations accounted for 30 percent of the increase. In the Federal system, 68 percent of the increase is attributable to drug violations. The Columbia study confirmed other research in what many of us believed intuitively, that recidivist offenders are most likely drug abusers. In State prisons, 41 percent of first-time offenders use drugs regularly. Compare that with two-time offenders, 63 percent of whom abuse drugs. Of those offenders who had 5 convictions or more, over 81 percent were regular drug users. The Columbia study concluded that our failure to provide adequate drug treatment programs in prisons was a missed opportunity to reduce crime and the myriad taxpayer cost associated with drug use.

The key question today is basic: Does drug treatment work? If the answer to that question is "Yes"; and that appears to be the consensus among health care professionals, social scientists, and experts in the criminal justice field, what can we do to optimize treatment outcomes and get the biggest bang for our buck? What ingredients are necessary for a successful drug treatment program? What systems need to be in place to maximize the impact of treatment, especially in our jails and prisons? How effective are drug courts in putting these ingredients together? And what can we in Congress do to make the system better?

I look forward to hearing the testimony of our witnesses today. We also expect to be joined shortly by Representative John Conyers, the distinguished ranking Democratic member of the Judiciary Committee. He will speak briefly about a bill he and I introduced together in March. The purpose of this bill, which is supported by the Justice Department and Office of National Drug Control Policy, is to free up prison construction funds and allow the States, if they choose, to spend the money on appropriate drug testing and drug treatment in the prisons. It is one important way to help break the cycle of drugs and crime.

Thank you, Mr. Chairman, and I look forward to hearing from the witnesses.

[The prepared statement of Hon. Thomas M. Barrett follows:]

Statement of Representative Tom Barrett
Hearing on Drug Treatment Programs and the Criminal Justice System
July 22, 1998

Thank you Mr. Chairman, and good morning to our two panels of witnesses. Today's hearing will focus on the effectiveness of drug treatment programs, particularly in the criminal justice system, and the potential of treatment to combat drug abuse and all of its attendant social problems -- crime, health care costs, social welfare costs, and lost productivity.

In January, the National Center on Addiction and Substance Abuse at Columbia University released a comprehensive study on the relationship between drug abuse and the growing prison population in our country. According to the dy, the prison population in federal and state systems has exploded over the past two decades. Between 1980 and 1996, the number of inmates in the United States more than tripled, from roughly 500,000 to more than 1.7 million. Drug abuse accounts for the lion's share of this increase. In the state prison system, convictions for drug violations accounted for 30% of the increase. In the federal system, 68% of the increase is attributable to drug violations.

The Columbia study confirmed other research and what many of us believed intuitively -- that recidivist offenders are most likely drug abusers. In state prisons, 41% of first offenders used drugs regularly. Compare that with 2-time offenders -- 63% of whom abused drugs. Of those offenders who had 5 convictions or more, over 81% were regular drug users. The Columbia study concluded that our failure to provide adequate drug treatment programs in prisons was a missed opportunity to

reduce crime and the myriad taxpayer costs associated with drug use.

The key question today, and one that I will pose to every witness, is basic -- Does drug treatment work? If the answer to that question is yes -- and that appears to be the consensus among health care professionals, social scientists, and experts in the criminal justice field -- then what can we do to optimize treatment outcomes and get the biggest bang for our buck? What ingredients are necessary for a successful drug treatment program? What systems need to be in place to maximize the impact of treatment, especially in our jails and prisons? How effective are drug courts in putting these ingredients together? And what can we, in Congress, do to make the system better?

I look forward to hearing the testimony of our witnesses today. We expect to be joined shortly by Representative John Conyers, the distinguished ranking Democratic member of the Judiciary Committee. He'll speak briefly about a bill that he and I introduced together in March. The purpose of the bill, which is supported by the Justice Department and the Office of National Drug Control policy, is to free up prison construction funds and allow the states, if they choose, to spend that money on appropriate drug testing and drug treatment in the prisons. It's one important way to help break the cycle of drugs and crime.

Mr. MICA. I thank the gentleman for his opening statement and I am pleased now to yield to the gentleman from Texas, Mr. Turner, for an opening statement.

Mr. TURNER. Thank you, Mr. Chairman. I welcome our witnesses as well, and I do agree, Mr. Chairman, that this is probably one of the most important issues this Congress can deal with. Having been active in trying to work not only here in Congress but previously in the Texas Legislature in combating drugs and supporting drug treatment efforts, I must say that I think it is important for us to recognize at the outset of this hearing that progress in drug treatment and success in drug treatment oftentimes is incremental and difficult to measure. And what some would consider a failure in terms of the statistics might in fact, in truth, be success rates. So it is a very difficult area.

I want to also say that in Texas, we have experimented successfully with funding faith-based drug treatment programs. And while it is very true that successful drug treatment programs must contain certain elements to be sure that they are working properly, the overlay of the emphasis on faith-based programs oftentimes has proven in Texas to be very successful. And so, though I think it would be an error to say that any program operating under the name of a faith-based program would be worthy of funding and worthy of support, I have found that there are many faith-based programs that operate on very sound principles, and when operated under those sound principles, the addition of a faith-based emphasis has proven very successful.

We understand that getting off drugs involves a very personal commitment on the part of the person receiving treatment, and oftentimes faith can be an important element in assisting them to successfully get off drugs. So I look forward to hearing from our witnesses today, and I am hopeful that the hearing will be productive and that this Congress can move forward in fighting the problem of drug abuse that is so widespread in this country.

Thank you, Mr. Chairman.

Mr. MICA. I thank the gentleman. At this time, I would like to welcome our first panel of experts. We have Dr. Donald Vereen, who is the Deputy Director of the Office of National Drug Control Policy. We have Dr. Marsha Lillie-Blanton, and she is an Associate Director of the U.S. General Accounting Office. Dr. Sally Satel is a psychiatrist at the Oasis Clinic. Dr. Eric Wish is director for the Center for Substance Abuse. Mr. Raymond Soucek is president of the Haymarket Center.

I am pleased to welcome our panelists. This is an investigative and oversight subcommittee of Congress, and we do swear in all of our witnesses, so if you would please stand and raise your right hands.

[Witnesses sworn.]

Mr. MICA. The record will reflect that the witnesses answered in the affirmative, and, again, I am pleased to welcome each of you to our panel this morning. Some of you I know have testified before and may be familiar, but we do try to limit your verbal and oral comments to this subcommittee to 5 minutes. If you have lengthy statements or additional material which you would like made a

part of the record, we will do that by unanimous consent. So we ask you to adhere to that rule.

And we will proceed at this time, first, by welcoming and recognizing Dr. Donald Vereen. Sir, you are recognized, and welcome.

STATEMENTS OF DONALD VEREEN, M.D., DEPUTY DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY; MARSHA LILLIE-BLANTON, ASSOCIATE DIRECTOR, GENERAL ACCOUNTING OFFICE; SALLY SATEL, M.D., PSYCHIATRIST, OASIS CLINIC; ERIC WISH, DIRECTOR, CENTER FOR SUBSTANCE ABUSE; AND RAYMOND SOUCEK, PRESIDENT, HAYMARKET CENTER

Dr. VEREEN. Good morning. On behalf of Director McCaffrey, I would like to thank the committee for the opportunity to testify today on the critically important matter of drug treatment in the criminal justice system.

As members of this committee well know, drug treatment is an essential component of our national strategy. You are familiar with the strategy that was developed to break the cycle of drugs and crime and reduce the hard core drug user population.

I am especially pleased to have the opportunity to address this issue now when Congress is approaching final decisions on the fiscal year 1999 National Drug Control Strategy and Budget, and it is of course important and the hope of Director McCaffrey and myself that the Congress will adopt the strategy and the budget as the interrelated whole that they represent.

It is very important to emphasize that the whole and its integrity is what is important, and treatment is a very important part of that and treatment within the criminal justice system.

But before I do that, it is important to recognize the members of this committee. Congressman Mica, your comments were right on target. The motivation, the experiences that you shared with us, make it very clear why this is an important issue and an important problem to tackle.

I want to recognize Chairman Hastert and Representative Barrett for your leadership in this area, and also to thank Representative Cummings for his support.

I have a written statement and I would like to ask that it be made a part of the record for the proceedings.

Mr. MICA. Without objection, so ordered.

Dr. VEREEN. I will be very brief.

The Congress has provided consistent bipartisan support for the drug treatment research agenda. The drug research budget has gone from $194.4 million in 1992 to $323.5 million in 1998. That is a 66.4-percent increase.

As the former Special Assistant to the Director of Medical Affairs at the National Institute on Drug Abuse, I am aware and appreciative of the budget support. Today, I ask the committee to consider the fruits of that research by assisting the Office of National Drug Control Policy in bringing Federal policy and resource allocation into agreement with what the research has been teaching us. It is a very important point that we will try to underscore here.

First, the research has demonstrated that drug treatment has a consistent and significant positive impact on criminal behavior,

drug use, employment, and disease transmission with its associated health care costs. We have several studies documented in the literature that have been submitted.

But, I have a picture to show you. Could we put this up quickly—so that you get a visual sense of the effects of drug treatment on the kinds of outcomes that we are interested in.

In terms of illicit drug use, there is a 50-percent decrease in illicit drug use after treatment. A particular study shows this decrease, on average, is effective 1 year and 18 months out. The point is there is a significant decrease in illicit drug use after treatment.

Drug selling behavior decreases even further. We are presenting this in the positive, with nearly 80-percent reduction in drug selling behavior. A decrease in arrests in the 1-year period after drug treatment is at 60-percent, a 60-percent decrease. There is more than 40-percent decrease in homelessness, another important outcome to observe. It is important to illustrate that drug use and its consequences are broad, and intervention at this level has broad outcomes as well.

As a recent Harvard study noted, even given its present state of development and uneven application when compared to other lifesaving interventions, drug treatment, in terms of net cost, life expectancy gain, and a couple other issues, substance abuse treatment ranks in the top 10 percent. For example, drug treatment compares at the same level of the successful treatments of diabetes mellitus, asthma, and hypertension. From the same set of issues that are associated with those chronic diseases and the outcomes associated with the treatments by the established medical profession, drug treatment compares very favorably at the same level.

Second, the research has identified areas in which drug treatment should and can be improved. Today I can say to you with confidence that we know how to deliver effective drug treatment and rehabilitation services. Our challenge is to make this information available in a clear and persuasive manner. We are working very hard on that.

Third, the research has identified areas in which current Federal policy and resource allocations run counter to what we know. We must make a course correction if we are to get the biggest public safety and public health bang for our buck.

Now a brief note on other recent scientific findings. Last week, the Family Research Council released the results of their poll of American voters. They found that 68 percent of those polled believe that providing drug treatment to inmates before they are released will reduce future crime. Even more impressive, 76 percent supported coercing addicts who commit crime into drug treatment programs. The source and the substance of these findings reinforce the practical sense of the American people and the nonpartisan nature of the growing national consensus on the importance of drug treatment. The science is clear, and quite apparently the American people have an understanding of this. The science is supporting what people are thinking and believing, and vice versa.

Finally, I respectfully ask the members of the committee and the entire Congress to join us in implementing the strategy. The strategy and drug budget are made up of mutually supportive and inter-

dependent parts, the resulting whole being greater, but requiring all of the parts.

We congratulate the House on its strong support for increasing the substance abuse block grant and drug court programs. On the other hand, we are quite disappointed that the modest $85 million drug intervention program, which would allow the Department of Justice to expand the "Breaking the Cycle" initiative by supporting testing treatment and graduated sanctions to more communities did not receive support. All of these are essential to our progress in breaking the cycle of drugs and crime. Without these elements, the very integrity of the 10-year strategy is threatened.

Furthermore, I think we can all agree that Federal policy should encourage, not hinder, State implementation of proven approaches. Congress should allow States to use Federal prison funding for testing and treatment and use Federal prison treatment funds for post-incarceration, transitional, and followup services. They are critical, and these simple steps, we believe, will bring our actions into closer conformance with our knowledge and that our return on our research investment then will be obvious. Thank you for your time and I look forward to answering any questions you may have.

[The prepared statement of Dr. Vereen follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Statement of Donald R. Vereen, Jr., MD, MPH
Deputy Director, Office of National Drug Control Policy
before the House Committee on Government Reform and Oversight -
Subcommittee on National Security, International Affairs,
and Criminal Justice, July 22, 1998

On behalf of Director McCaffrey, I would like to thank the Committee for the opportunity to testify today on the critically important matter of drug treatment in the criminal justice system. As members of this committee well know, drug treatment is an essential component of our *National Strategy* to break the cycle of drugs and crime and reduce the hardcore user population. I am especially pleased to have this opportunity now, when the Congress is approaching final decisions on the FY 1999 *National Drug Control Strategy* and budget. It is of course the hope of Director McCaffrey and myself that the Congress will adopt the *Strategy* and budget as the inter-related whole they represent. The integrity of the *Strategy* hinges on implementation of all its elements.

Before I move on to the topic, I would like to recognize the members of this Committee for your commitment to reducing illegal drug use and its consequences. Chairman Hastert, Representative Barrett, we appreciate your leadership. I would also like to thank Representative Cummings for his steadfast support. I have prepared a written statement and I ask that it be made part of the record of these proceedings. My oral statement will be brief.

The Congress has provided consistent, bi-partisan support for the drug treatment research agenda. The drug treatment research budget has gone from $194.4 million in 1992 to $323.5 million in 1998 an increase of 66.4%, with a 1999 request of $353.8 million, an increase of 30.3%.

As the former Special Assistant to the Director for Medical Affairs at the National Institute on Drug Abuse, I am keenly aware and appreciative of that support. Today, I ask the Committee to consider the fruits of that research and assist the Office of National Drug Control Policy in bringing Federal policy and resource allocation into agreement with what the research has taught us.

DRUG TREATMENT IS EFFECTIVE

Research has demonstrated that drug treatment has a consistent, significant, positive impact on criminal behavior, drug use, employment, and disease transmission with its associated

health care costs. As a recent Harvard study ("Five Hundred Life-Saving Interventions and Their Cost Effectiveness") noted, all substance abuse treatments rank in the top 10 percent of life-saving interventions, in terms of net cost and life expectancy gain. This is the case, even given the present state of development and uneven application of drug treatment.

SROS - 1998

The Services Research Outcome Study (SROS) of the Substance Abuse and Mental health Services Administration (SAMHSA) is the largest long-term study of treatment effectiveness. SROS studied outcomes for a national sample representing 1.1 million individuals five years after discharge from treatment in 1989 and 1990. Because SROS addressed drug treatment as it existed in 1989 and 1990, and because it included individuals who dropped out of treatment after a very short time, modest results might be expected. However, SROS found:

- 21 percent (156,000) fewer users of any illicit drugs, five years after discharge;
    - cocaine users were reduced by 45 percent,
    - marijuana users by 28 percent,
    - crack users by 17 percent, and
    - heroin users by 14 percent.
- In addition, SROS found:
    - 14 percent (126,000) fewer users of alcohol;
    - 56 percent (48,000) fewer stealing cars,
    - 38 percent (50,000) fewer breaking and entering,
    - 30 percent (101,000) fewer selling drugs,
    - 23 percent (28,000) fewer victimizing others;
    - 38 percent fewer injecting drugs, and
    - 34 percent fewer homeless.

Longer stays in treatment predicted greater reductions in alcohol and drug use and criminality. SROS found certain areas of significant challenge. Forty-nine percent were readmitted for an average of two episodes during the follow up period: 77 percent of those treated for heroin use, 69 percent of those who previously had three or more episodes of outpatient methadone treatment, 65 percent of those who had dropped out of treatment within the first week, and 61 percent of those treated for crack use. Those under age 18 at the time of discharge actually experienced increases in alcohol and crack use and drug-related crime.

In summary, longer stays in treatment predicted greater reductions in alcohol and drug use and

criminality.

DATOS - 1997

The Drug Abuse Treatment Outcome Study (DATOS), sponsored by the National Institute on Drug Abuse, compared before and after treatment behaviors of 10,010 drug abusers in nearly 100 treatment programs, representing various treatment modalities in 11 cities. A random sample of nearly 3,000 patients interviewed 12 months after treatment yielded the following findings:

- Among participants in outpatient methadone treatment, the number of weekly heroin users decreased 69 percent, weekly cocaine users decreased 48 percent and illegal activity decreased 52 percent.

- Among participants in long-term residential treatment, heroin use decreased 66 percent, cocaine use decreased 67 percent, illegal activity decreased 61 percent, and unemployment decreased 13 percent.

- Among participants in outpatient drug-free treatment, marijuana use decreased 64 percent, cocaine use decreased 57 percent, illegal activity decreased 56 percent, and unemployment dropped by 7 percent.

- Among participants in short-term inpatient treatment, marijuana use decreased 63 percent, cocaine use decreased 69 percent, illegal activity decreased 58 percent, and no significant change was found in unemployment.

In summary, treatment resulted in marked decreases in drug use and illegal behavior across the board and generally resulted in increases in employment.

NTIES - 1997

The Congressionally-mandated National Treatment Improvement Evaluation Study (NTIES) was conducted by the Center for Substance Abuse Treatment (CSAT). NTIES determined the persistent (12 month follow up) effects of substance treatment on predominately poor, inner-city populations as follows:

- use of illicit drugs dropped an average of 50 percent;

- drug selling by 78 percent, shoplifting by 82 percent, and arrests by 64 percent;

- exchange of sex for money or drugs dropped by 56 percent;

- Homelessness dropped by 43 percent and receipt of welfare income by 11 percent; and
- employment increased 19 percent.

PUBLIC SAFETY RESEARCH

- The 1998 interim report of the evaluation of the Federal Bureau of Prisons' (BOP) Drug Treatment Program (a collaborative effort of NIDA and BOP) found that six months after release, the population receiving treatment was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than the control group;
- The 1997 report of the NIDA-funded Evaluation of the Delaware Prisons Drug Treatment Program found that 18 months after release the population that received institutional and transitional treatment was 57 percent less likely to be re-arrested and 37 percent less likely to use drugs than the non-treatment population;
- Colorado followed up on treatment graduates and found that, among those who had been arrested in the 2 years prior to treatment, 80 percent had no arrests and 94 percent had no DUI arrests;
- Maine followed treatment graduates for a year and found that 78 percent had no arrests;
- Washington found that, after 4 years, substance abusing traffic offenders diverted from prosecution to treatment had a 22 percent recidivism rate compared to 48 percent for those who had been convicted; and
- Texas found, after a 1 year follow up of treatment graduates, that 80 percent had no arrests.

Adult Drug Courts

According to the Bureau of Justice Statistics, in June 1997, the nation's prisons and jails held 1,725,842 men and women -- an increase of more than 96,100 over the prior year. The increase in drug offenders accounts for nearly three-quarters of the growth in the federal prison population between 1985 and 1995. During the same period the number of inmates in state prisons for drug law violations increased by 478 percent.

We cannot arrest our way out of the drug problem. Drug courts represent a solution.

There are nearly 400 drug courts in 275 jurisdictions in the United States today, up from the

dozen that existed in 1994. More than 100,000 persons have entered drug courts, 70 percent of whom have either graduated or remain as active participants. ONDCP is aiming to have 2000 drug courts by the year 2000.

Although the program is young, a number of evaluations has been completed. A recent, scholarly review of 30 of these evaluations, addressing 24 drug courts, concluded:

- Drug courts are able to engage and retain felony offenders in programmatic and treatment services. Only 26 percent of drug court participants had been in prior substance abuse treatment, while 72 percent had been in jail or prison. 60 percent of those who enter drug courts are still in treatment after one year, roughly double the retention rate for most community treatment programs.

- Drug courts provide more comprehensive and closer supervision than other community programs. In 1997, 55 percent of drug courts required at least two drug tests a week during early phases of the program, 35 percent required weekly tests, and 10 percent bi-weekly tests. This compares to pre-drug court probation, with 8 percent of the jurisdictions reporting weekly tests, 52 percent monthly, 33 percent less frequent than monthly, and 6 percent no testing at all. Again in 1997, 74 percent of reporting drug courts held status hearings at least bi-weekly during early phases of the program, and 24 percent did so monthly. This compares to pre-drug court probation, where only 27 percent of probationers had face-to-face meetings with their probation officers more often than monthly.

- Drug use and criminal behavior are substantially reduced during drug court participation. A survey of 13 drug courts found a positive drug test rate of 10 percent compared to 31 percent for probationers not in drug court. Santa Clara County, California found a drug court positive rate of 5.4 percent compared to 10.2 percent for offenders in electronic monitoring, 13.2 percent for offenders in intensive supervision probation, and 24.5 percent for offenders under general probation supervision. Ventura County, California experienced a 12 percent drug court rearrest rate compared to 32 percent for th comparison group; the numbers for Jackson County, Missouri were 4 percent and 13 percent respectively.

- Criminal behavior is lower after participation, especially for graduates. In eight jurisdictions studied, rearrest rates were consistently lower among drug court participants.

- Drug courts generate cost savings from reduced jail and prison use, reduced criminality, and lower criminal justice system costs. Outpatient drug treatment can run between approximately $2,000 to $4,000 per year compared with approximately $25,000 to $31,000 to incarcerate a person for one year. Multnomah County, Oregon calculated criminal justice savings of $2.5 million over a two year period; Riverside County,

California saved more than $2 million annually, and the Honolulu drug court averted costs of between $700,000 and $800,000.

- Drug courts have spurred cooperation within the criminal justice system and between the criminal justice system and the drug treatment and social services systems.

Juvenile Drug Courts

There are only 37 operational juvenile drug courts and very few completed evaluations. Early findings indicate that retention is about the same as for adults (nearly 70 percent) and recidivism to drug use and crime are markedly lower, especially among program graduates.

Some particularly instructive, if anecdotal, information about the relationship of drug treatment to the criminal justice system was generated by the juvenile drug court in Santa Clara County. Participants were asked to identify what had the greatest impact on their ability to stay drug-free. Their answers underscore the potent combination presented by the criminal justice and treatment systems acting in concert. They identified: constant monitoring and support by their probation officer; having to face the judge and explain their behavior; urine testing; positive reinforcement from the drug treatment team; expectations from the court; not wanting to let staff down; and a sense of humor by the drug treatment team.

These young people have in essence identified the elements for effective treatment and management of criminal justice populations. Get to them as early as possible; employ a formal assessment as a basis for the treatment and rehabilitation plan, and for tracking progress; employ swift, graduated, and palpable incentives and sanctions; and maintain unbroken supervisory and support contact. The need for structure is apparently even greater for juveniles than for adults.

These principles can be expressed more completely as follows. All treatment programs should be required to employ a comprehensive assessment instrument at the point of intake, and to update that assessment periodically during the course of treatment and recovery. Programs must be required to assess progress and to respond to the lack of progress. All treatment programs should be required to develop a formal, long-term rehabilitation plan, in accordance with the results of the assessment; and review and revise it in accordance with periodic assessments. This must include the initial intensive therapy and pharmacology and the longer term recovery plan. All formal treatment interventions should include specific, realistic relapse prevention training and compliance motivation training, during the initial course of treatment and as a continuing part of recovery.

Consequences for non-compliance should be established clearly; they should be graduated and employed swiftly and fairly. Treatment programs should be held accountable for results in light of the relative difficulty of the population they serve, as determined by the initial, comprehensive assessment. Finally, a formal supervision and support person or organization should be

designated for each person who completes the initial stage of treatment, to provide management and supervision and ensure continuing compliance with the recovery plan.

TREATMENT CAN GET BETTER

Research has identified areas in which drug treatment can and should be improved. Today, I can say to you with confidence, we know how to deliver effective drug treatment and rehabilitation services. Our challenge is to make this information available in a clear and persuasive manner.

Treatment Models. Among the essential steps toward maintaining effective treatment in a managed care environment, is the development and dissemination of treatment models -- models that describe the essential elements of treatment and the processes required to engage, retain, and successfully graduate treatment clients. After years of focusing almost entirely on post-treatment outcomes -- most often drug use and criminal behavior -- researchers have begun to look more carefully into the elements and dynamics of treatment.

Given that treatment retention for 90 or more days appears to be the key to many interim and long-term outcomes, the question we must answer is what predicts retention into and through that critical 3rd month? Analysis of data from the Drug Abuse Treatment Outcome Study (DATOS) yields some significant findings.

- The counselor is the key to engagement. A positive therapeutic relationship in the first month -- client respect for the counselor and counselor rapport with the client -- predicts session attendance in the first three months, which along with educational class attendance, predicts behavioral compliance in the third month (re: drug use, illegal activities, and psychosocial adjustment), which in turn predicts longer stay in treatment and participation in "aftercare."

- The therapeutic focus and strategy -- the tools the counselor uses -- are obviously of importance. Research and clinical experience suggest that: goal setting (with tools like contingency management and mapping); empathy building; and problem solving are among the elements of effective treatment.

We will continue to support research along these lines, to improve the delivery of treatment services and to protect the integrity of effective approaches from uninformed cost cutting.

Treatment Improvement Protocols and Therapy Manuals for Drug Addiction. The Center for Substance Abuse Treatment (CSAT) has published 26 Treatment Improvement Protocols (TIPS), four addressed to specific juvenile and criminal justice populations, which give research-based guidance for the development and conduct of a wide range of treatment programs. In

concert with the TIPs initiative, CSAT created 11 Addiction Technology Transfer Centers (ATTC), which cover 24 states and Puerto Rico. The purpose of these university-based centers is to train substance abuse counselors and related health, social service, and criminal justice professionals. TIPs serve as the basis for comprehensive training packages and courses developed and disseminated by the centers. Three TIPs have been established as priorities for development, including a criminal justice TIP. In addition to these packages, the ATTCs have developed a set of addiction counselor competencies that serves as the basis for practice guidelines employed by such organizations as the National Association of Alcohol and Drug Addiction Counselors (NAADAC). A comprehensive evaluation of TIPs will begin this year.

To ensure that the treatment providers apply the most current science-based approaches to their patients, NIDA has supported the development of the "Therapy Manuals for Drug Addiction" series. This series reflects NIDA's commitment to rapidly applying basic findings in real-life settings. Manuals are now available for the conduct of cognitive-behavioral and community reinforcement approaches to treating cocaine addiction.

The Contributions of National Organizations. National health care professional and provider organizations are key to the delivery of effective treatment. The efforts of these organizations advance the field of drug treatment by their research and dissemination of state-of-the art treatment approaches.

One important example is the American Society of Addiction Medicine (ASAM), which has exercised national leadership in establishing assessment and placement criteria for addiction treatment. Another is Therapeutic Communities of America (TCA), which in concert with the Ohio Department of Alcohol and Drug Addiction, has developed a comprehensive set of operating standards for prison-based therapeutic communities (TCs) -- over 120 standards across 11 program domains. With ONDCP support, these standards will now be validated through field tests in operational prison settings A Standards Evaluation Trial will be conducted at up to six prison sites. Standards will be validated or revised based on these reviews. Final standards will be put into a format appropriate for accreditation of TC programs in correctional settings, for use by organizations such as the American Correctional Association (ACA).

National Conferences. The research and the experience of seasoned practitioners tell us how to deliver effective treatment to criminal justice populations -- how rehabilitation services must be structured and what elements are essential. Yet programs are too often conducted on a partial and piecemeal basis -- where elements central to treatment success are inadequate or missing altogether. To bring the established research to light as part of our national commitment, ONDCP is conducting a two-phased assessment. First, in March, a Consensus Meeting among scholars and practitioners was held to determine and disseminate the content and limits of the science addressing the delivery of rehabilitation services to drug dependent criminal justice populations. The March meeting will provide the outline for a major white paper and 1999

Strategy chapter on treatment in the criminal justice system. A major national conference will follow, tentatively scheduled for the fall of 1998, which will develop the March results and provide a strategic action plan.

While still under review, the findings from the March conference address a number of policy areas.

- **Transitional Services**. Criminal justice and other institutional treatment programs must focus more attention on transition back to the community. Continuity of service is important to stable recovery, and continuing supervision is an effective way to counter the offender's tendency to manipulation and risk of relapse. Effective transition can be accomplished with outreach to community programs by the institution, "reach-in" to the institution by community programs, or planning and monitoring by a 3rd party, like a TASC program. Establishing a systematic transition program can enable institutions to target and vary intensity and duration of institutional and community treatment, depending on the crime and drug history of offenders (For example, lower risk offenders might be offered shorter institutional treatment followed by intensive transitional community treatment services.)

- **Coercion and Internal Motivation**. Research suggests that more attention needs to be focused on internal motivation as a predictor of and an important contributor to stable positive results from drug treatment. Coercion is clearly justified by results -- treatment entry and initial retention. And coercion is essential for hardcore users who ultimately benefit most from treatment. However, external force (coercion) alone can be counter productive when applied to an individual who has not recognized substance abuse as being problematic, and it will not sustain recovery. Internal motivation is important to measure as a good predictor of success and important to foster as a basis for stable recovery. For best results, treatment should be lengthy, structured, flexible, and evaluated regularly.

- **Systematic Policy Approach**. Systemic policies are the proper focus for efforts to link treatment with the criminal justice system. The tendency of the criminal justice system to focus on programs rather than system policy results in continued, episodic treatment of small percentages of the population in need. To move past coordination around specific programs to systems integration requires systematic case management and clearly defined policies regarding critical elements and roles in the delivery of the related services. Treatment is difficult -- research indicates that 25 to 35 percent offered treatment picked jail time instead. Coercion is appropriate but insufficient for stable recovery -- the treatment process itself can foster internal motivation over time.

- **Prison Treatment Programs**. The therapeutic community (TC) modality has proven effective in reducing criminal recidivism and drug use among criminal justice

populations. Over 80 percent of the admissions to community TCs have criminal histories and most of the residential programs in state prisons are modified TCs. The most consistent reductions are found when institutional programs are followed by transitional or aftercare programs, especially when these post-institutional programs are consistent with and continue the treatment begun in the institution. Despite this record of success, it remains true that most drug-dependent inmates do not volunteer for treatment in prison, many who enter drop out, and most who enter do not volunteer to continue their treatment after release. Therefore, the fostering of individual motivation must be a focus of treatment policy and programs in the criminal justice system.

- **Fostering Retention**. A significant proportion of patients enter drug treatment with limited or short-lived motivation. It is therefore incumbent on the treatment process to proceed in a way that fosters engagement early as a way to ensure retention and, with it, reinforcing behavioral improvements. To do this requires that the initial treatment process be focused on factors related most directly to retention -- self-rated motivation, self-rated therapeutic relationship, in-treatment drug taking, and frequency of session attendance. Positive behavior on one or more of these measures tends to predict positive behavior on the others, and in concert these measures foster retention, which, in turn, reenforces the positive behaviors.

Breaking the Cycle. The Office of National Drug Control Policy has worked closely with the Departments of Justice and Health and Human Services to design an approach that will allow communities to safely and effectively work with drug dependent offenders. The resulting "Breaking the Cycle" concept offers the promise of reducing the wasteful incarceration of offenders who can be successfully supervised and rehabilitated at the community level.

Breaking the Cycle will demonstrate the impact of a systematic response to chronic, hardcore drug use. The program encompasses the integrated application of testing, assessment, referral, supervision, treatment and rehabilitation planning and delivery, routine progress reporting to maintain informed judicial oversight, graduated sanctions for noncompliance, relapse prevention training and skill building, and structured transition back into the mainstream community.

The program began its Phase I implementation in Birmingham, Alabama, on June 2, 1997. Phase I includes all offenders charged with drug possession and/or forged prescriptions. Since its inception, nearly 2,000 offenders have been assessed and admitted to the program. During the month of May alone, over 1,600 drug tests were administered for active BTC participants. In July the program will reach full implementation with all offenders required to participate as a condition of their release from jail. The program is being documented and evaluated by the National Institute of Justice and additional sites, juvenile as well as adult, will be selected for participation in 1998.

Drug-Free Prison Zone Demonstration Project. The Drug-Free Prison Zone Demonstration Project is a $6 million initiative being conducted jointly by ONDCP, the National Institute of Corrections (NIC), and the Federal Bureau of Prisons (BOP) to interdict and control the availability of drugs in prisons. Demonstration projects will commence in Federal prisons in 1998, and at selected State prisons by next year. Activities include: regular inmate drug testing; advanced technologies for drug detection; and training of correctional and other institutional staff.

BOP will test ion spectrometry drug detection equipment at 28 BOP facilities. This technology provides the capability to quickly and accurately detect microscopic traces of drugs (e.g., cocaine, heroin, methamphetamine, PCP, LSD, and THC) on an individual's skin and clothing, as well as on other surfaces. Ninety day tests of this technology, at the Federal Correctional Institution Tucson and Metropolitan Detention Center Los Angeles, resulted in reduction in the rate of serious drug-related inmate misconduct (e.g., introduction, use, or possession of drugs) of 86 percent and 58 percent respectively.

AREAS OF NEEDED CHANGE

A brief note on other recent findings. Last week the Family Research Council released the results of their poll of American voters. They found that 68 percent of those polled believe that providing drug treatment to inmates, before they are released, will reduce future crime. Even more impressive, 76 percent support coercing addicts, who commit crime, into drug treatment programs. The source and substance of these findings reinforce the practical sense of the American people and the non-partisan nature of the growing national consensus on the importance of drug treatment. The science is clear and the people's view of what is needed is in line with what the science shows.

Finally, I respectfully ask the members of this committee and the entire Congress to join us in implementing the *Strategy*. The Strategy and drug budget are made up of mutually supportive and interdependent parts, the resulting whole being greater than but requiring all of its parts.

We appreciate the House for its strong support of the substance abuse block grant and drug court programs. On the other hand, we would advocate that the modest $85 million drug intervention program -- allowing the Department of Justice to expand the "Breaking the Cycle" initiative, by bringing testing, treatment, and graduated sanctions to more communities, remains an important initiative. We are disappointed this did not receive Congressional support. All are essential to our progress in breaking the cycle of drugs and crime.

Furthermore, I think we can all agree that Federal policy should encourage not hinder state implementation of proven approaches. Congress should allow the states to use federal

prison funding for testing and treatment, and to use federal prison drug treatment funds for post-incarceration, transitional and follow up services that are critical to supervised reentry into the community.

These simple steps will bring our actions into closer conformance with our knowledge. They are the return on your research investment. Thank you. I will be happy to answer any questions.

Mr. MICA. Thank you, Dr. Vereen, for your comments. We are going to withhold any questions until we finish the whole panel.

I want to take just a moment to congratulate our Director of the National Office of Drug Control Policy, General McCaffrey, for his leadership and his outspokenness that I think was very wanted toward policy in the Netherlands. The legalization that the country has experimented with is indeed disastrous, and he has been very courageous in making those statements and sticking to his guns. And that, followed by his performance on the needle exchange program, we are really pleased with the cooperation.

Finally, just as a footnote, we are interested in putting whatever resources that can be justified from the Congress to the Department of Justice and other agencies. We will work with you, and that indeed is one of the reasons for this hearing, to determine what is effective and what funds can be used and what treatment programs will work.

With those quick comments, I would like to now recognize Dr. Marsha Lillie-Blanton, who is the Associate Director of the U.S. General Accounting Office. Welcome, and you are recognized.

Ms. LILLIE-BLANTON. I would like to thank you for inviting me, and I would also like to ask if my full testimony could be entered into the record.

Mr. MICA. Without objection, so ordered.

Ms. LILLIE-BLANTON. Each year, the Federal Government, States, and private entities spend billions of dollars on drug treatment. The Federal Government alone spent $3.2 billion in fiscal year 1998, representing 20 percent of the Federal drug control budget. It is estimated that about 2.4 million individuals obtained some form of drug treatment in 1996, the most recent year for which data are available.

Because drug treatment is a significant component of the Nation's drug control strategy, you asked us to provide you with information on what is known about the effectiveness of drug treatment. My comments are based on our review and synthesis of findings for major evaluations of drug abuse treatment effectiveness.

In brief, we found that several large multisite longitudinal studies have produced considerable evidence that drug abuse treatment is beneficial to the individual in treatment and to society. However, growing concerns about the validity of self-reported data on drug use suggests that the benefits of treatment reported by these studies may be overstated.

Now I would like to talk specifically about our major findings in the report. First, based on several major studies conducted over a period of nearly 30 years, there is consistent evidence, as has already been said, that a substantial proportion of clients being studied report reductions in drug use and criminal activity at least 1 year following treatment.

The most recent of these studies, the drug abuse treatment outcome study, called DATOS, found, for example, drug use among a sample of clients in a residential treatment program was reduced by more than half, from 66 percent of the clients reporting weekly or more frequent cocaine use in the year prior to treatment, to 22 percent reporting regular cocaine use after treatment. Also, preda-

tory illegal activity was reduced by more than half, from 41 percent of the clients to 16 percent after treatment.

Involvement in criminal activity is one of several outcome measures generally assessed in evaluations of drug treatment. This is partly because the link between drug use and criminal activity is not inconsequential. At least half of the people brought into the Nation's criminal justice system have a substance abuse problem and a large percentage of the participants in the studies we reviewed were involved with the criminal justice system. For example, 56 percent of DATOS clients reported being on probation, on parole, or awaiting trial. As such, the benefits of treatment are generally measured in terms of reductions in not only drug use, but in criminal activity as well.

Our second major finding is concerned with the quality of the evidence on the effectiveness of treatment. Because all of the effectiveness studies relied on information reported by the clients, the level of benefit derived from treatment may be overstated. Although this method of data collection is commonly used in national surveys and drug abuse treatment evaluations, recent questions about the validity of self-reported drug use raised concerns about this approach. A recent National Institute of Drug Abuse review of current research on clients in the criminal justice system and clients formerly in treatment suggests that 50 percent or fewer current users accurately report their drug use.

As questions have developed about the accuracy of self-reported data, researchers have begun using more objective means to validate such data. For example, researchers involved in the national treatment improvement evaluation study, called NTIES, collected objective measures of drug use on a subset of clients and found that 20 percent of those in the validation group acknowledged cocaine use within the past 30 days. Urinalysis revealed recent cocaine use to be 29 percent. Because the results from the major studies of treatment effectiveness were not adjusted for the likelihood of underreported drug use, as was found in NTIES, the reductions in drug use found may be overstated.

Finally, our last finding focused on evidence that is available for specific groups of drug users. Using Federal dollars most effectively requires an understanding of which approaches work best for different groups of drug users. On this subject, however, research findings are less definitive. Although strong evidence supports methadone maintenance as the most effective treatment for heroin addiction, less is known about the best ways to provide treatment service to cocaine users or to adolescents.

For cocaine abusers, a number of pharmacotherapies have been studied and some have proven successful in one or more clinical trials. No medication, however, has demonstrated substantial efficacy, once subjected to several rigorously controlled trials. And without a pharmacologic agent, treatment practitioners have relied on cognitive behavioral therapies to treat cocaine addiction.

For adolescents, a population we talked about for which there is great concern because of growing use of drugs among teens, the evidence is also less definitive. Although family based intervention shows promise as an effective treatment for adolescents, no one

treatment approach has been shown to be consistently superior to others in achieving better treatment outcomes for this population.

In conclusion, the Federal Government currently provides substantial support for drug treatment. Monitoring the performance of treatment programs can help ensure that we are making progress to achieve the Nation's drug control goals. Although studies conducted over nearly three decades consistently show that treatment reduces drug use and crime, current data collection techniques do not allow accurate measurement of the extent to which treatment reduces the use of illicit drugs.

This concludes my prepared statement and I will be happy to answer any questions you or members of the subcommittee may have.

[The prepared statement of Ms. Lillie-Blanton follows:]

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our recent report on drug abuse treatment research findings.[1] As you know, illicit drug use in the United States remains a serious and costly problem. In a 1996 survey, about 13 million Americans reported using illicit drugs in the past month. Each year, as many as 11,000 deaths are linked to illicit drug use. To combat the nation's drug abuse problem, the federal government and states spend about $27 billion annually. Further, the total annual cost of illicit drug use to society is estimated at $67 billion for costs associated with health care and drug addiction prevention and treatment programs, drug-related crime, and lost resources resulting from reduced worker productivity or death.

Because drug abuse treatment is a significant component of the nation's drug control strategy, you asked us to examine the major research findings on drug abuse treatment effectiveness. My remarks today will focus on (1) the overall effectiveness of drug abuse treatment; (2) the methodological issues affecting drug abuse treatment evaluations; and (3) what is known about the effectiveness of specific treatments for heroin, cocaine, and adolescent drug addiction. My comments are based on our review and synthesis of findings from major evaluations of drug abuse treatment effectiveness.

In brief, we found that large, multisite, longitudinal studies have produced considerable evidence that drug abuse treatment is beneficial to the individual undergoing treatment and to society. The studies have consistently found that a substantial proportion of clients being studied report reductions in drug use and criminal activity following treatment. The studies also show that clients who stay in treatment for longer periods report better outcomes. However, drug abuse treatment research is complicated by a number of methodological challenges that make it difficult to accurately measure the extent to which treatment reduces drug use. In particular, growing concerns about the validity of self-reported data, which are used routinely in the major evaluations of drug abuse treatment, suggest that the treatment benefit reported by these studies may be somewhat overstated In addition, the research evidence to support the relative effectiveness of specific treatment approaches or settings for particular groups of drug abusers is limited While one specific treatment approach–methadone maintenance–has been shown to be the most effective treatment for heroin addiction, research on the best treatment approach or setting for cocaine addiction or adolescent drug users is less definitive.

---

[1]Drug Abuse: Research Shows Treatment Is Effective, but Benefits May Be Overstated (GAO/HEHS-98-72, Mar. 27, 1998).

BACKGROUND

In general, drug abuse is defined by the level and pattern of drug consumption and the severity of resulting functional problems. People who are dependent on drugs often use multiple drugs and have substantial health and social problems, including mental health disorders. One of the many challenges to providing effective treatment for addiction is the complicated nature of the disorder. Unlike other chronic diseases, drug addiction extends beyond physiological influence to include significant behavioral and psychological aspects. For example, specific environmental cues that a drug abuser associates with drug use can trigger craving and precipitate relapse, even after long periods of abstinence. Therefore, drug abusers may enter treatment a number of times, often reducing drug use incrementally with each treatment episode.

Despite the potential for relapse to drug use, not all drug users require treatment to discontinue use. For those who require treatment, services are provided in either outpatient or inpatient settings and via two major approaches–pharmacotherapy and behavioral therapy–with many programs combining elements of both. Although abstinence from illicit drug use is the central goal of all drug abuse treatment, researchers and program staff commonly accept reductions in drug use and criminal behavior as realistic, interim goals.

Since the early 1990s, federal spending for drug abuse treatment has grown steadily. Of the approximately $16 billion budgeted for drug control activities in fiscal year 1998, drug abuse treatment accounted for $3.2 billion, or 20 percent. Over half of federal drug abuse treatment funds were allocated to the Department of Health and Human Services (HHS) to support block grants to the states, drug abuse treatment services, and related research. An additional third of treatment dollars are spent by the Department of Veterans Affairs to support drug abuse treatment services to veterans and their inpatient and outpatient medical care. To meet the requirements of the Government Performance and Results Act of 1993, agencies are beginning to set goals and performance measures to monitor and assess the effectiveness of federally funded drug abuse treatment efforts. However, demonstrating the efficient and effective use of federal drug abuse treatment funds is particularly challenging because most of these funds support services provided by state and local grantees, which are given broad discretion in how best to use them.

RESEARCH CONSISTENTLY DEMONSTRATES BENEFITS OF DRUG ABUSE TREATMENT

In numerous large-scale studies examining the outcomes of drug abuse treatment provided in a variety of settings, researchers have concluded that treatment is beneficial. Clients receiving treatment report reductions in drug use and criminal activity as well as other positive outcomes. The studies have also demonstrated that better treatment

outcomes are associated with longer treatment periods but have found that retaining clients in treatment programs is problematic.

Major Studies Report Reductions in Drug Use and Crime Following Treatment

Comprehensive analyses of the effectiveness of drug abuse treatment have been conducted by several major, federally funded studies over a period of nearly 30 years: the Drug Abuse Treatment Outcome Study (DATOS), the National Treatment Improvement Evaluation Study (NTIES), the Treatment Outcome Prospective Study (TOPS), and the Drug Abuse Reporting Program (DARP). These large, multisite studies--conducted by research organizations independent of the groups operating the treatment programs being assessed--were designed to measure people's involvement in illicit drug and criminal activity before, during, and after treatment. Although the studies report on reductions in drug use from the year prior to treatment to the year after, most also track a subset of treatment clients for followup interviews over longer time periods. For example, DARP followed clients for as long as 12 years, TOPS for 3 to 5 years following treatment, and DATOS researchers are planning additional followup to determine long-term outcomes. These studies are generally considered by the research community to be the major evaluations of drug abuse treatment effectiveness, and much of what is known about "typical" drug abuse treatment outcomes comes from these studies.[2]

All of these major studies, which have evaluated the progress of thousands of people, concluded that drug abuse treatment was effective when outcomes were assessed 1 year after treatment. They found that reported drug use declined when clients received services through any of three drug abuse treatment approaches--residential long-term, outpatient drug-free, or outpatient methadone maintenance--regardless of the drug and client type.[3] DATOS found that, of the individuals in long-term residential treatment, 66

---

[2]See Institute of Medicine, Treating Drug Problems (Washington, D.C.: Institute of Medicine, 1990) See also "Drug Abuse Treatment Outcome Study (DATOS)," Psychology of Addictive Behaviors, Vol. 11, No. 4 (1997), pp. 211-323. For information on NTIES, see The National Treatment Improvement Evaluation Study--Final Report (Mar. 1997), prepared by the National Opinion Research Center at the University of Chicago in collaboration with the Research Triangle Institute for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

[3]In its 1990 report, Treating Drug Problems, the Institute of Medicine concluded there was little evidence to suggest that hospital-based chemical dependency programs, a type of inpatient treatment, were either more or less effective for treating drug problems than chemical dependency programs not located in hospitals. DATOS found that clients receiving treatment in short-term inpatient programs reported substantial reductions in drug use, but statistical analysis did not show that the reductions were attributable to the

percent reported weekly or more frequent cocaine use in the year prior to treatment, while 22 percent reported regular cocaine use in the year following treatment. Also, 41 percent of this same group reported engaging in predatory illegal activity in the year prior to treatment, while 16 percent reported such activity in the year after treatment.

Previous studies found similar reductions in drug use and criminal activity. For example, researchers from the 1980s TOPS study found that across all types of drug abuse treatment, 40 to 50 percent of regular heroin and cocaine users who spent at least 3 months in treatment reported near abstinence during the year after treatment, and an additional 30 percent reported reducing their use. Only 17 percent of NTIES clients reported arrests in the year following treatment–down from 48 percent during the year before treatment.

Longer Treatment Episodes Have Better Outcomes, but Treatment Duration Is Limited by Client Drop-Out

Another finding across these studies is that clients who stay in treatment longer report better outcomes. For the DATOS clients that reported drug use when entering treatment, fewer of those in treatment for more than 3 months reported continuing drug use than those in treatment for less than 3 months. DATOS researchers also found that the most positive outcomes for clients in methadone maintenance were for those who remained in treatment for at least 12 months. Earlier studies reported similar results. Both DARP and TOPS found that reports of drug use were reduced most for clients who stayed in treatment at least 3 months, regardless of the treatment setting.

Although these studies show better results for longer treatment episodes, they found that many clients dropped out of treatment long before reaching the minimum length of treatment episode recommended by those operating the treatment program. For example, a study of a subset of DATOS clients found that all of the participating methadone maintenance programs recommend 2 or more years of treatment, but the median treatment episode by clients was about 1 year. Long-term residential programs participating in DATOS generally recommended a treatment duration of 9 months or longer, while outpatient drug-free programs recommended at least 6 months in treatment; for both program types, the median treatment episode was 3 months.

---

treatment.

TREATMENT BENEFITS MAY BE OVERSTATED BY MAJOR STUDIES

Because all of the effectiveness studies relied on information reported by the clients, the level of treatment benefit reported may be overstated. Typically, drug abusers were interviewed before they entered treatment and again following treatment and asked about their use of illicit drugs, their involvement in criminal activity, and other drug-related behaviors.[4] Although this data collection method is commonly used in national surveys and drug abuse treatment evaluations, recent questions about the validity of self-reported drug use raise concerns about this approach. In general, self-reporting is least valid for (1) the more stigmatized drugs, such as cocaine; (2) recent use; and (3) those involved with the criminal justice system. A recent National Institute on Drug Abuse (NIDA) review of current research on the validity of self-reported drug use highlights the limitations of data collected in this manner.[5] According to this review, recent studies conducted with criminal justice clients (such as people on parole, on probation, or awaiting trail) and former treatment clients suggest that 50 percent or fewer current users accurately report their drug use in confidential interviews.

As questions have developed about the accuracy of self-reported data,[6] researchers have begun using more objective means, such as urinalysis, to validate such data. For example, NTIES researchers found that 20 percent of those in a validation group acknowledged cocaine use within the past 30 days, but urinalysis revealed recent cocaine use by 29 percent. TOPS researchers reported that only 40 percent of the individuals testing positive for cocaine 24 months after treatment had reported using the drug in the previous 3 days.

---

[4]A large percentage of the clients participating in the studies we reviewed were involved with the criminal justice system. For example, 56 percent of DATOS clients reported being on probation or parole or awaiting trial when they entered treatment; 31 percent of DATOS clients were referred into treatment by the courts.

[5]National Institutes of Health, The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates, National Institute on Drug Abuse Research Monograph Series 167 (Washington, D.C.: HHS, 1997).

[6]The research literature prior to the mid-1980s showed drug use self-reporting to be generally valid, while studies conducted since then have raised concerns about validity. The apparent change in validity may be due in part to improved urinalysis testing that now detects drug use more accurately. It is also possible that individuals were more willing to admit to using illicit drugs when societal reaction toward drug use was not as strong as it is today. Even today, researchers are not in agreement on the limitations of self-reported data. For example, the researchers for DATOS, the most recently completed study of drug treatment, acknowledged limitations to self-reported data but asserted that most of these data are reasonably reliable and valid.

Because results from the major studies of treatment effectiveness were not adjusted for the likelihood of underreported drug use, reductions in drug use found may be overstated. However, researchers emphasize that client reporting on use of illicit drugs during the previous year (the outcome measure used in most effectiveness evaluations) has been shown to be more accurate than client reporting on current drug use (the measure used to assess the validity of self-reported data). Therefore, they believe that the overall findings of treatment benefits are still valid.

Although supplementary data collection, such as hair analysis or urinalysis, can help validate the accuracy of self-reported data, these tools also have limitations. Urine tests can accurately detect illicit drugs for about 48 hours following drug use but do not provide any information about drug use during the previous year. In addition, individual differences in metabolism rates can affect the outcomes of urinalysis tests. Hair analysis has received attention because it can detect drug use over a longer time–up to several months. However, unresolved issues in hair testing include variability across drugs in the accuracy of detection, the potential for passive contamination, and the relative effect of different hair color or type on cocaine accumulation in the hair. We have reported on the limitations of using self-reported data in estimating the prevalence of drug use and concluded that hair testing merited further evaluation as a means of confirming self-reported drug use.[7]

EVIDENCE VARIES ON THE BEST TREATMENT APPROACHES FOR SPECIFIC GROUPS OF DRUG ABUSERS

Using federal treatment dollars most effectively requires an understanding of which approaches work best for different groups of drug abusers, but on this subject, research findings are less definitive. Although strong evidence supports methadone maintenance as the most effective treatment for heroin addiction, less is known about the best ways to provide treatment services to cocaine users or adolescents.

In addition, client and program-related factors can affect client success. For example, outpatient drug abuse treatment programs operate with different numbers and quality of staff and have varying levels of coordination with local agencies that offer related services generally needed to support recovering abusers. A treatment program with close ties to local service providers, such as health clinics and job training programs, is likely to have better treatment outcomes than a program without such ties. Similarly, client factors, such as motivation and readiness for treatment or psychiatric status, can significantly affect the patient's performance in treatment. Current research generally

---

[7]See Drug Use Measurement: Strengths, Limitations, and Recommendations for Improvement (GAO/PEMD-93-18, June 25, 1993)

does not account for these factors in evaluating the effectiveness of alternative approaches for specific groups of drug abusers.

Research Supports Methadone Maintenance as the Most Effective Treatment for Heroin Addiction

Methadone maintenance is the most commonly used treatment for heroin addiction, and numerous studies have shown that those receiving methadone maintenance treatment have better outcomes than those who go untreated or use other treatment approaches. Methadone maintenance reduces heroin use and criminal activity and improves social functioning. HIV risk is also minimized, since needle usage is reduced.

As we have previously reported, outcomes among methadone programs have varied greatly, in part because of the substantial differences in treatment practices across the nation.[8] For example, in 1990, we found that many methadone clinics routinely provided clients dosage levels that were lower than optimum–or even subthreshold–and discontinued treatment too soon. In late 1997, an National Institutes of Health consensus panel concluded that people who are addicted to heroin or other opiates should have broader access to methadone maintenance treatment programs and recommended that federal regulations allow additional physicians and pharmacies to prescribe and dispense methadone.

Similarly, several studies conducted over the past decade show that when counseling, psychotherapy, health care, and social services are provided along with methadone maintenance, treatment outcomes improve significantly. However, the recent findings from DATOS suggest that the provision of these ancillary services–both the number and variety–has eroded considerably during the past 2 decades across all treatment settings. DATOS researchers also noted that the percentage of clients reporting unmet needs was higher than the percentage in previous studies.

Cognitive-Behavioral Treatments Show Promise for Cocaine Addiction

Evidence of a best approach to treat cocaine addiction is not as clear as it is for heroin addiction. Although a number of pharmacotherapies have been studied and some have proven successful in one or more clinical trials, no medication has demonstrated substantial efficacy once subjected to several rigorously controlled trials. Without a pharmacological agent, researchers have relied on cognitive-behavioral therapies to treat cocaine addiction.

---

[8]See Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990).

Studies have shown that clients receiving cognitive-behavioral therapy have achieved long periods of abstinence and have been successful at staying in treatment.[9] The cognitive-behavioral therapies are based largely on counseling and education. One approach, relapse prevention, focuses on teaching clients how to identify and manage high-risk, or "trigger," situations that contribute to drug relapse. A study of this approach showed cocaine-dependent clients were able to remain abstinent at least 70 percent of the time while in treatment. Another technique, community reinforcement/contingency management, establishes a link between behavior and consequence by rewarding abstinence and reprimanding drug use. A program using this approach found that 42 percent of the participating cocaine-dependent clients were able to achieve nearly 4 months of continuous abstinence. A third approach, neurobehavioral therapy, addresses a client's behavioral, emotional, cognitive, and relational problems at each stage of recovery. One neurobehavioral program showed that 38 percent of the clients were abstinent at the 6-month followup.

Family Therapy Is Under Study
for Adolescent Drug Abusers

Drug use among teenagers is a growing concern. It is estimated that 9 percent of teenagers were current drug users in 1996–up from 5.3 percent in 1992. Unfortunately, no one method has been shown to be consistently superior to others in achieving better treatment outcomes for this group. Rather, studies show that success in treatment for adolescents seems to be linked to the characteristics of program staff, the availability of special services, and family participation.

Many experts believe that family-based intervention shows promise as an effective treatment for adolescent drug abusers. This approach, based on the assumption that family behaviors contribute to the adolescent's decision to use drugs, was identified by a 1997 study and literature review as superior to other treatment approaches.[10] In fact, some researchers believe that family interventions are critical to the success of any treatment approach for adolescent drug abusers because family-related factors–such as parental substance use, poor parent-child relations, and poor parent supervision–have been identified as risk factors for the development of substance abuse among adolescents. However, NIDA acknowledged in a recently published article that further

---

[9]See Cocaine Treatment: Early Results From Various Approaches (GAO-HEHS-96-80, June 7, 1996).

[10]M. D. Stanton and W. R. Shadish, "Outcome, Attrition, and Family/Couples Treatment for Drug Abuse: A Meta-Analysis and Review of the Controlled, Comparative Studies," Psychology Bulletin, Vol. 122 (1997), pp. 170-91.

research is needed to identify the best approach to treating adolescent drug abusers.[11] Similarly, the American Academy of Child and Adolescent Psychiatry acknowledged in its 1997 treatment practice parameters that research on drug abuse treatment for adolescents has failed to demonstrate the superiority of one treatment approach over another.[12]

CONCLUSIONS

With an annual expenditure of more than $3 billion--20 percent of the federal drug control budget--the federal government provides significant support for drug abuse treatment activities. Monitoring the performance of treatment programs can help ensure that we are making progress to achieve the nation's drug control goals. Research on the effectiveness of drug abuse treatment, however, is problematic given the methodological challenges and numerous factors that influence the results of treatment. Although studies conducted over nearly 3 decades consistently show that treatment reduces drug use and crime, current data collection techniques do not allow accurate measurement of the extent to which treatment reduces the use of illicit drugs

- - - - -

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you and other members of the Subcommittee may have.

(108376)

[11]Naimah Z. Weinberg, M.D., and others, "Adolescent Substance Abuse: A Review of the Past 10 Years," Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 37, No. 3 (Mar. 1998), pp. 252-61.

[12]Oscar Bukstein, M.D. (principal author) and the Washington Group on Quality Issues, "Practical Parameters for the Assessment and Treatment of Children and Adolescents With Substance Use Disorders," Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 36, No. 10, Supp. (Oct. 1997), pp. 1405-1565.

Mr. MICA. Thank you for your testimony. I would now like to recognize Dr. Sally Satel, who is a psychiatrist with the Oasis Clinic. Welcome, and you are recognized.

Dr. SATEL. Thank you for inviting me today. I do agree with the findings of the GAO report that benefits of treatment are probably overstated, but it is also true that drug treatment can work to help patients lead a drug-free life.

And that is my subject today: How to make it more effective than it currently is. And the answer in short is leverage; going by other names, external pressure, coercion, being forced into treatment, involuntary treatment, basically knowing there are going to be consequences for drug use.

We know three things about treatment. One is that it works, and here I am going to define "work" as meaning abstinence after treatment, not reduction in use, but abstinence. It is completion of treatment that is important. But few patients complete it. Maybe 1 in 5 actually finish. The dropout rates are very big. So the challenge of treatment is really retention.

The second thing we know is that addicts do not have to be motivated initially to quit drugs in order for treatment to work. That is counterintuitive, you may not have heard it. People don't necessarily have to be out of so-called denial in order to benefit from treatment.

The third point, and this is the one I want to focus on. People like me, the treatment providers on the front line, need all the help we can get; help in getting people into treatment and keeping them there until they finish it. And we need the help from other social institutions, like the workplace, the criminal justice system, even the housing authority and the welfare system, because these can help us exert leverage. What I want to do now is discuss leverage and the various places in the system through which it can be applied.

The first one would be the workplace. I am just going to cite you a recent study here from the University of Pennsylvania. The researchers looked at a group of transportation workers from a union in Philadelphia. If anyone tested positive, they had to go to treatment. The researchers compared the people who were forced to go into treatment, who were told if you don't go to treatment, you have lost your job. They compared them to the patients who volunteered for treatments. These patients said "I have a drug problem, I better get treatment." The patients who were coerced stayed longer in treatment and both groups did about as well, again illustrating one can be coerced into a treatment program and have a successful outcome.

Also, there is the housing domain. There is an interesting study by Jesse Milby, a psychologist at the University of Alabama, who worked with homeless crack addicts. Dr. Milby did not put them in conventional treatment but rather in a work-therapy program where they refurbished condemned houses. They got a modest amount of money for that, and they could also live there, in the refurbished houses if their urines were clean. After 6 months, those who were in the work-therapy program were far more likely to be clean, using less cocaine and had fewer days of homelessness, than those in regular treatment.

Then we come to drug court, something Dr. Vereen mentioned. These offer nonviolent repeat offenders the possibility of dismissed charges if they complete a treatment program. These are heavily monitored treatment programs. The judge meets with the participants, sometimes weekly, at least monthly, and there are what is called graduated sanctions. These are very important for infractions. Graduated sanction means a small punishment the first time you mess up; have a positive urine or miss a session, maybe 1 day in jail; then 2 days in jail the next time, 3 days in jail; finally you can overstep the limits. But those kind of graduated sanctions are very effective: they are certain, and they are swift and they are not really set that severe. Retention rates in drug court treatment is 4 to 5 times that of regular treatment, and drug court participants have lower rearrest rates than those adjudicated in the traditional way.

I also wanted to mention a little bit about the domain of public service. For example, there is the Doe Foundation in New York City. It operates something called a ready, willing and able training program, and its shelters require that participants or residents in those shelters be drug free. Recently, the foundation took over a 192-bed shelter in New York. Sixty-two percent of the people in that shelter tested positive. Once they instituted their policy of regular drug testing, 2 percent were testing positive. Now more nonprofit homeless shelters and churches are imposing this sort of arrangement.

My patients readily admit to me that external pressure helps. One patient said he was going to look for a job as a truckdriver, just because he knew he would get urine testing and someone would be looking over his shoulder. I also had a patient who was relieved that his employers were going to start drug testing on the job. I have had women patients whose welfare runs out because their youngest child turns 18 and they have to get a job and they stop using. Now this is methadone, so these are people who are also using cocaine, for example.

Finally, a woman entered a job training program where there was drug testing and she stopped, but, again, not until they started testing in her job training program. So you can imagine I was horrified when I saw a patient who said he was on parole. This was a patient whose urines were consistently positive, and I said, "What does your parole officer do?" He said, "He tests me." I said, "What does he do when you are positive?" The patient says, "Oh, nothing, because he says 'you're in treatment so it is OK.'" No, this is not the way to help the patient. I depend on that parole officer to help me to set limits.

So, the point I want to conclude with is that consequences matter. Clinicians need all the help they can get and the more reinforcement from other social institutions, the better. Thank you very much. I have a full statement I hope you will include in the record.

Mr. MICA. Thank you, and we will include your entire statement as part of the record.

[The prepared statement of Dr. Satel follows:]

STATEMENT

SALLY L. SATEL MD
Psychiatrist, Oasis Clinic, Washington DC
Lecturer, Yale University School of Medicine

Subcommittee on National Security, International Affairs
and Criminal Justice
Committee on Government Reform and Oversight
U.S. House of Representatives

July 22, 1998

Effectiveness of Drug Abuse Treatment: Drug Treatment Can Work Better with Leverage

Mr. Chairman and Members of the Committee:

Thank you for inviting me today. I have worked in the addiction field as a clinician and researcher for ten years now and agree with the findings of the GAO report, that the benefits of treatment are overstated.* Indeed, I believe that many of my patients could achieve greater progress in treatment if they were compelled to experience more meaningful consequences and rewards in their efforts to become abstinent.

I will talk about enhancing treatment through leverage, that is, by using external pressure (coercion) to shape behavior.

1. Emphasize "user accountability" by linking drug use to consequences — Sanctions and rewards are key in shaping behavior: they are a rational prescription for people who engage in problem behavior. The very reason people recover from addiction is because relapse to drugs is under voluntary control. It is a behavioral condition, not a no-fault medical illness or a "chronic and relapsing brain disease," as some are now calling, it.

---

* *The GAO report appropriately emphasizes the unreliability of self-reported improvement. Indeed, while the magnitude of improvement may be exaggerated by patients themselves, numerous studies in which urine screens and criminal records are carefully checked — small-scale clinical studies (and larger ones by M. Douglas Anglin of UCLA's Drug Abuse Research Center) as well as criminal justice evaluations — confirm that drug use and drug-related crime decline with treatment.*

2. Realize that abstinence requires constant reinforcement -- Treatment programs are routinely undermined because social institutions (workplace, public housing, welfare systems)don't reinforce abstinence and hold patients accountable. Though well-intended, social safety-nets cushion the painful consequences of addiction, such "enabling" by society often sabotages my work with patients because it provides perverse incentives to continue drug use. It is the very fact that the consequences are painful that provides the impetus for recovery.

3. Capitalize on the fact that coercion works — That addicts must be motivated to quit drugs and voluntarily enter treatment in order to benefit from it is a common misconception.

I will expand upon these points presently, but it is important to realize that, despite the likely "overstatement" of benefits, drug treatment is an excellent social investment. Even if savings are not as great as recent socioeconomic analyses have suggested, there is good evidence that drug treatment saves money by averting crime and drug-related illness and by leading to resumed employment. Thus, even if we did nothing at all to improve patient outcomes, treatment-as-usual is both humane and economically sound. (1)

My message today is that treatment can be made much more effective. As mentioned, there are real benefits to reducing drug use and drug-related crime, but the ultimate goal of treatment — occasionally reached — is to help patients achieve enduring abstinence and full social productivity. Those goals hinge on people like me — the front-line clinician — having leverage. Without it, the problems of patient drop out and relapse will persist.

Critical importance of retention in treatment

Studies show that while patients are in treatment their drug use and criminal activity are much reduced. However, since few patients complete programs, enduring abstinence is not typically achieved. Nevertheless, considerable reductions in drug use and crime are consistently demonstrated at the time of release and persist over one or more years later. Large scale studies from the National Institute on Drug Abuse (NIDA) found abstinence rates of 30 - 50% among those who stayed in treatment for at least three months. Since only half stayed that long, it is clear that most patients do not achieve abstinence after a treatment episode. (2)

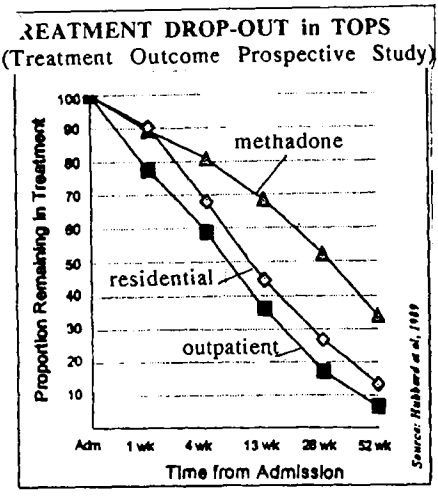
When patients complete treatment, however, success rates are high. For example,

over 70% of patients who graduate from 12 - 24 months long residential treatment at Phoenix House are drug-free and 90% are employed and uninvolved with crime five years after graduation. The problem is: less than 1 in 5 actually complete programs.

Patient Drop-Out

Retaining patients in treatment is a most pressing challenge. Large epidemiological studies sponsored by the NIDA (e.g., Drug Abuse Research Project (DARP); Treatment Outcome Prospective Study (TOPS), Drug Abuse Treatment Outcomes Study (DATOS)) revealed high rates of attrition with half of their subjects dropping out after three months, the threshold at which the long-term personal and cost-saving benefits of treatment only begin to accrue.

Attrition rates in the major studies were high. Among DARP patients 13% completed outpatient treatment, 20% completed TC treatment and 28% completed methadone maintenance. These high drop-out rates were associated with a pattern of re-admission to the same or another clinic within a few years. During the 12 year follow-up period, for example, the average addict in outpatient treatment had 3.4 more treatment admissions, one in a TC had 4.6 more admissions and one in methadone maintenance had 5.1 more treatment admissions.



Attrition in TOPS and DATOS was also considerable. In TOPS, 8% finished a year in outpatient, 12% a year in a TC and 33% a year in methadone. Among DATOS patients, about 5% finished one year in outpatient, 8% a TC and 44% methadone. A number of factors likely account for what appears to be a trend toward declining retention include the shrinking of adjunct social services provided by the clinic and a higher proportion of cocaine abusers in later studies and thus fewer patients overall who could benefit from the stabilizing effect of methadone). The proportion of younger patients and multiple-drug abusers — features associated with poorer prognoses — has also increased. In addition, a higher proportion of women in the later studies may also contribute to the attrition trend.

External Pressure Keeps Patients In Treatment

Clinicians naturally prefer their patients to exhibit a readiness for treatment."Treatment will only work if the patient is out of denial and in it for himself," goes the popular clinical wisdom Yet, at the time of entry into treatment, many patients actually report being pressured to quit by external influences. Still, the addict who seeks treatment in response to threats and entreaties from his spouse, boss, physician or landlord is prompted by self-interest: either he is trying to maintain a personal attachment or preserve some asset.

What about addicts who seem to have nothing to lose and no desire for treatment but who are legally required to participate? Can they benefit from a process that has been assumed to require motivation? The answer is yes. Counterintuitive as it seems, initial motivation is not always a prerequisite for successful treatment. Numerous studies show that involuntary patients are as likely, sometimes more likely, to benefit from treatment as voluntary patients.

The finding that **length of time spent in treatment is a reliable predictor of outcome** was replicated by each of the government's three large scale outcome studies. Taken together, these studies assessed roughly 70,000 patients of whom 30 - 50% were legally referred or legally involved. In addition, **individuals who were referred by the criminal justice system stayed significantly longer** than referrals from other sources. By contrast, DARP found no correlation between criminal justice status and retention or improvement in treatment. At the very least, then, DARP patients who were legally referred performed no worse than voluntary individuals. Individuals who are legally referred to therapeutic communities averaged more days in treatment than voluntary patients. Most likely, this represents a balancing-out of two opposite forces. First, the more criminally involved the patient, the less favorable his performance in treatment (especially his rate of arrest in the post-treatment phase). Second, the retention-enhancing effect of legal referral offsets the higher probability of negative outcomes among the criminally involved.

Examples of leverage that work: swift, certain, though not necessarily severe

Although coercive strategies -- external pressure to attend and remain in treatment -- employ sanctions and consequences that its critics regard as punitive or intrusive, both the intent and, usually, the result of their application are therapeutic -- that is, they help reduce drug abuse and the dysfunctional and deviant behaviors for which it is often a marker.

Contracting

The obvious strategy behind contracting is to confer some advantage on people who manifest a desired behavior, and, conversely, to penalize them for violating an agreement. Recall the old public service announcement: "Help an addict: threaten to fire him." Contracting, or "soft" coercion, includes private arrangements with employers through Employee Assistance Programs and professional societies for impaired doctors, nurses, lawyers and pilots wherein the individual is allowed to keep his job or his license "in exchange" for abstaining from illicit drugs or problem alcohol use.

Before describing, contracting as a policy, I want to describe researchers' application of the principles of contracting in treating substance abusers.

Contingency Management — The goal of contingency management (CM) interventions is to arrange environmental consequences (rewards and/or punishments) to systematically weaken drug use and strengthen the skills necessary for abstinence. The underlying behavioral theory, operant conditioning, holds that the act of using drugs can be modified by its consequences.

The earliest CM studies were conducted with alcoholics. Miller and colleagues examined whether CM could be used to reduce public drunkenness. Twenty alcoholic men were selected from the city jail in Jackson, Mississippi and randomly assigned to an experimental or control group. If they reduced their drinking, those in the experimental group could earn housing, employment, food and medical care through cooperating local social service agencies. Men in the control group received services as well but they were not contingent upon being sober. Alcohol intake was assessed objectively via breath alcohol level or by observation of gross intoxication. During the two month study arrests in the CM group decreased 85% but remained steady in the non-contingent comparison group. (3)

Steven Higgins and colleagues at the University of Vermont have conducted numerous CM trials with cocaine addicts. At the end of the 24-week course of study, 75% of the voucher group remained in treatment compared to 40% of the no-voucher group. Significantly lower levels of self-reported cocaine use in the voucher group persisted at 9 and 12 months after treatment entry. (4)

A similar study with inner city cocaine addicts was performed by Ken Silverman and colleagues at Johns Hopkins University in Baltimore. At the end of the 3-month study period, cocaine use was substantially reduced in the experimental group but remained largely unchanged in the comparison group. About half of the patients

exposed to contingent vouchers achieved between 7 and 12 weeks of continuous abstinence; less than 5% of the control patients attained only 3 consecutive weeks abstinence. As in most other CM studies, there tends to be a rebound resumption of drug use after the vouchers are discontinued, but the experimental groups reliably perform significantly better at all stages of follow-up. (5)

Jesse Milby of the University of Alabama also conducted a study with potential real-world application. After two months of intensive daily therapy, the enhanced group was eligible to participate in a work-therapy program refurbishing condemned houses. For a modest rental fee, they could also live in the housing but participation in the work program and housing were contingent on submitting twice weekly clean urine tests. After six months individuals in this group achieved significantly greater improvement in employment, fewer days of homelessness and less cocaine use than those in the usual care group. (6)

A major drawback to CM is patients' the tendency to resume drug use, albeit at a lower level than before treatment, when the contract is withdrawn. This may be due, in part, to the short months-long duration of the research projects. A few months is not enough time to enable the person to learn new skills, secure a job and attain the measure of personal growth needed to live drug-free. Another problem is the cost of the vouchers; inthese studies the "rewards" were written into the grant budget or researchers solicited donations from local businesses but real-world treatment can not offer monetary incentives.

Contracting and entitlements — The public entitlement system provides a natural laboratory for demonstrating the potential of CM for shaping the behavior of drug abusing recipients. Conceivably, disability payments, welfare benefits, veterans benefits or other naturally occurring form of cash entitlement could be dispensed in accordance with the principles of CM.

At Harborview Medical Center in Seattle, psychiatrist Richard K. Ries directs a clinic for mentally ill substance abusers. Patients are requested to sign over their SSI check to the outpatient clinic which then acts as the "representative payee" and manages bank accounts for the patient-recipients. Rent and other basics are covered by the payee and the patient is allowed to "earn back" discretionary funds through compliance with treatment, and ultimately control of his passbook to the bank account, when he has demonstrated the ability to manage money responsibly. Reis and colleagues compared treatment outcomes between patients entered into the payee/incentive arrangement and those receiving treatment-as-usual. Over a three-month period, these sicker patients were significantly more likely to attend treatment sessions as their more healthy

counterparts and as likely to participate in job training sessions and to stay out of the hospital and jail. (7)

The manipulation of benefits to reinforce positive social behavior could be a partial solution to the perverse incentives that entitlements often pose. Street ethnographers have long known that addicts routinely purchase drugs with welfare payments and food stamps but recent quantitative reports have described a reliable temporal pattern in which the receipt of monthly benefits are linked to periodic rises in emergency room visits for intoxication, overdoses and hospitalizations for psychosis in cocaine-abusing schizophrenics. Currently, the West Haven, Connecticut and West Los Angeles Veterans Affairs Medical Centers are planning a CM project that would distribute veterans' service connected benefits in a contingent fashion to mentally ill substance abusers.

Increasingly, public services are fighting to adopt this quid pro quo philosophy. Alphonso Jackson was president of the Housing Authority of the City of Dallas from 1989 to 1996 and became a crusader is public accountability. During his tenure in the housing authority, he was the subject of numerous lawsuits filed by ACLU and legal aid organizations because he asked tenants to agree to undergo drug testing as a condition of living in the special Self Sufficiency Program within Dallas public housing. (Unfortunately, Jackson was not allowed to implement his plan).

Similarly, the Doe Foundation in New York City, which operates the Ready, Willing and Able training program and shelter, requires applicants be drug-free as a condition of acceptance and, once enrolled, drug-tests its trainees routinely. Recently, the Foundation took over a 192-bed shelter: initially, 62% of residents tested positive on scheduled, announced tests. Nine months later, only 2% were testing positive on random tests. Many not-for-profit homeless shelters and churches also require abstinence as a condition of receiving services and there is even a state-funded methadone clinic in Baltimore that requires that its patients be employed and drug-free a condition of remaining in the program.

Welfare reform legislation, too, has stimulated many states and localities to revise the procedures for awarding benefits. Montgomery County, Maryland, for example, now denies benefits to applicants who refuse to undergo drug testing. With problem substance use among welfare recipients estimated between 15% and 30% (some individual states, according to the Legal Action Center, put it as high as 50%), the efficiency of surveillance and sanctioning procedures will be put to the test.

Employee Assistance Programs -- EAP's are a good example of therapeutic coercion in action. These programs were first established in the 1940's by employers concerned about the impact of employee alcoholism on workplace safety and productivity. According to the Employee Assistance Professionals Association there are about 20,000 EAPs. Four of five Fortune 500 companies have an EAP. Mandatory referrals to treatment as an alternative to dismissal from work represent a significant portion of the caseload, ranging from 20 - 60%.

In a recent study, researchers at the University of Pennsylvania studied drug-using transportation and city service union members in Philadelphia. Coerced individuals were more likely to complete a course of treatment than were self referred workers (77% vs. 61% finished one month of inpatient care while 74% vs. 60% graduated from a series of outpatient counseling sessions). At 6 month follow-up, 92% of workers were re-interviewed. (8)

Criminal Coercion

Drug Courts — To break the cycle of drug-related crime, drug courts offer non-violent, usually repeat offenders, the possibility of dismissed charges if they plead guilty and agree to a heavily monitored drug treatment-and-testing program that is closely overseen by a judge. Infractions (e.g., positive urines, missed sessions) are met with increasing penalties. According to the National Association of Drug Court Professionals, there are almost 400 drug courts in operation, up from about 20 in 1994. (9)

During the late 80's, southern Florida was hit hard by drug-related arrests that flooded courtrooms and overwhelmed jail space. Meanwhile, addicts out on probation were quickly re-arrested for new drug crimes and the revolving door to the justice system was spinning out of control. Drug court provided a way to break that door by processing cases efficiently, distinguishing between criminal addicts and addicted criminals and "reserving" jail and prison beds for dangerous offenders.

The accumulated evidence of drug courts' effectiveness has yet to reach a critical threshold — there are only a handful of independently evaluated studies — but early data look promising. For example, a 1998 assessment of the Portland drug court was recently completed by the State Justice Institute. On outcome measures (e.g., re-arrest, conviction two years after leaving program), those who did not enter drug court were at least twice as likely to have subsequent felony arrests as those who did. Among enrollees, non-completers (less than three months in the program) were about twice as likely to be arrested as were graduates. Of note, individuals who completed at least three months had significantly fewer arrests than those who did not. (10)

In almost all drug courts, retention in court-ordered drug treatment is consistently higher than in voluntary treatment. Thus, drug court is a meaningful route of entry into

rehabilitation since over 70% of drug court participant have been incarcerated at least once, almost three times more than have been in drug treatment. (9) General Accounting Office found that the average retention rate for drug court programs was a very respectable 71% -- even the lowest rate of 31% exceeds the average retention rate of about 15% at one year for non-criminal addicts in public sector treatment programs. (11) Since criminally involved addicts are normally considered the hardest to treat in conventional settings, the drug court retention results are even more impressive. And the longer participants stayed in drug court, the better they fared.

According to information maintained by the Drug Court Clearinghouse atAmerican University, differences in re-arrest rates are significant. Drug courts operational for 18 months or more reported a completion rate of 48%. Depending upon the characteristics and degree of social dysfunction of the graduates, rearrest — for drug crimes, primarily — was 4% within one year of graduation. Even among those who never finished the program (about 1 in 3 fail to complete) re-arrest one year after enrollment ranged from 5 - 28%. Contrast this with the 26 - 40% re-arrest rate among traditionally adjudicated individuals convicted of drug possession who will commit another offense within one year, according to the Bureau of Justice Statistics.

Enlist Other Institutions to Impose Consequences and Reward Abstinence

The **workplace** and **public housing** have already been mentioned as venues at which drug testing (routine and "for cause") can be implemented. Combined with graduated sanctions, monitoring should be more widespread and include **probationers and parolees**. (12)

Welfare reform provides an excellent opportunity to transform the perverse reward of public entitlements into constructive incentives that promote autonomy and recovery using the very same, naturally-occurring benefits that the system already offers. For example, women would receive weekly disbursements of "discretionary" cash (in addition to food stamps and rental subsidy) by turning in clean drug screens and/or complying with drug treatment). **Disability payments** and **veterans service-connected benefits** could also be adapted to this model.

Key points

1. The **virtues of coercion** are:

a. more substance abusers would enter treatment than would otherwise enroll voluntarily,

b. the likelihood of success in treatment is improved; at the very least, coerced patients do no worse than voluntary patients,

c. addicts enter treatment earlier in their substance abuse "careers," when intervention can produce greater lifetime benefits.

2. **Clinicians need all the leverage they can get.** The more reinforcement from other social institutions, the better.

3, Addiction **is a behavioral condition for which the prescription of choice is the reliable imposition of consequences and rewards,** often in a coercive context that ensures the patient's retention. This is not punitive, it is a rational clinical approach with a proven track record.

Notes

(1) "Socioeconomic Evaluations of Addictions Treatment," President's Commission on Model State Drug Laws, Dec. 1993; California Drug and Alcohol Treatment Assessment, 1994. (2) Simpson DD, Sells SB: 1983. Advances in Alcohol and Substance Abuse 2: 7 - 29; Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, J.H., Cavanugh E.R. and H.M. Ginzburg. 1989. Drug Abuse Treatment: A National Study of Effectiveness. Chapel Hill, N.C.: University of North Carolina Press; Simpson, D.D. and S.J. Curry (eds.) Special Issue: Drug Abuse Treatment Outcome Study. In Psychology of Addictive Behaviors. Dec. 1997. Also note: Good reviews of coercion in treatment: Leukefeld, C.G. and F.M. Tims. 1988. Compulsory Treatment of Drug Abuse Research and Clinical Practice NIDA Research Monograph 86, DHHS Publication No. ADM 89-1578. Washington DC: U.S. Government Press; Anglin, M.D. and Y. Hser. 1990. Legal coercion and drug abuse treatment: research findings and social policy implications In J A Inciardi (ed) Handbook of Drug Control in the United States. New York, Greenwood Press.(3) Miller, P.M. 1975. Arch Gen Psychiatry 32:915-918.(4) Higgins ST, Tidey JW, Stitzer ML. In (Graham AW, Schultz TK.) American Society of Addiction Medicine Principles of Addiction Medicine, 2nd ed. (In press); (5) Silverman, K., Chutuape, M.A., Bigelow, G.E., Stitzer, M. 1996 Drug and Alcohol Dependence 40:115-123. (6) Milby, J.B., Schumacher, J.E., Raesynski, J.M., Caldwell, E., Engle, M., Michael, M. and J. Carr. 1996 Drug and Alcohol Dependence 43:23-38. (7) Ries, R in press, American Journal on Addiction (8) Lewantal, E., McLellan, A.T. et. al. 1996 J Substance Abuse Treatment 8(1):115 - 128. Also see Group for the Advancement of Psychiatry Report No. 137 1994 Forced into Treatment: The Role of Coercion in Clinical Practice. Washington, D.C.: American Psychiatric Press. (9) Belenko, S. 1998 National Drug Court Institute Review. 1(1):1-44. (10) Finigan M: 1998 An Outcome Evaluation of the Multnomah County S.T.O.P. Drug Diversion Program. Alexandria, Va: State Justice Institute; Experimental designs are difficult to implement (11) U.S. General Accounting Office, 1997. Drug Courts: Overview of Growth, Characteristics and Results Washington DC: US General Accounting Office.(12) Kleiman, MAR. (1997) In Mead, L.M. (ed) The New Paternalism: Supervisory Approaches to Poverty. Washington, D.C.: Brookings Institution Press.

Mr. MICA. I am now pleased to recognize Dr. Eric Wish, who is director of Center for Substance Abuse. Welcome, and you are recognized, sir.

Mr. WISH. Thank you, Mr. Chairman, and thank you to the other members of the subcommittee for the privilege to address you this morning.

Good morning. I speak today as a psychologist with over 25 years of experience doing substance abuse research, and I am not going to bore you with a lot of my background. It is in my written remarks and additional materials, which I am requesting you place in the record.

Mr. MICA. Without objection, so ordered.

Mr. WISH. But I would like to, for a moment, tell you a short story. I was at a national conference a year or so ago and a very brilliant social scientist came up to me and said, "You know, Eric, you've spent your career studying the obvious." Actually, he said, "proving the obvious." So I picked myself up off the floor and I said to him, "What do you mean?" He said to me, "How could anyone in this day and age expect other people to admit to using cocaine?"

I spent much of my career looking at drug use and offenders, primarily by using urinalysis, and in 1984 I established a research study funded by the National Institute of Justice in which I collected urine samples, voluntary anonymous urine samples, from basically about 5,000 people who had been recently arrested and were charged with anything you might be charged with in coming through the booking facility. And we found at that time, 42 percent of the people arrested tested positive for cocaine, meaning almost half had used cocaine in the last 2 to 3 days. When we went back 2 years later in 1986, that number had moved to 80 percent.

That study showed that many more arrestees tested positive for cocaine metabolite than admitted recent use of the drug in confidential research interviews. These findings provide indisputable evidence, that was subsequently replicated in numerous studies, that researchers, let alone criminal justice personnel, would greatly underestimate current drug use in a detainee population if they relied solely on people to accurately report their current use of illegal drugs. For example, we went into the supervision probation program in Brooklyn and found about six times more users of cocaine—this is among probationers—than their probation officers thought were using the drug, and that was based on the urine testing.

Since doing the research in New York City, the Department of Justice and the National Institute of Justice established the DUF program, and the types of findings I presented to you on the drug use in arrestees in Manhattan has been replicated across the country. We are basically—regardless of charge, about anywhere from 40 to 70 percent of the people who are arrested and processed test positive for an illicit drug.

My thesis today is simple. A growing body of research studies provide convincing evidence that in the 1990's, researchers must rely on more than self-reports to estimate recent illegal drug use. I emphasize in the 1990's, because we live in a period of zero tolerance of any illegal drug use and even of the use of some legal drugs like tobacco products and alcohol.

It is difficult to believe today that in 1974, Dr. Peter Bourne, who later became President Carter's drug policy advisor, said that he could not understand DEA's efforts to interdict cocaine, "the most benign of illicit drugs currently in widespread use."

How different a society we live in today, where our children are bombarded with commercials warning them of the consequences from using illegal drugs. Our society's increasing stigmatization of illegal drug use, in addition to the whole fear of HIV, affects survey respondents' willingness to report illegal drug use and explains why researchers find more underreporting of drug use in studies conducted today than in studies conducted when drug use was considered more benign. So much of the research in the seventies and early eighties could show that people might admit to their drug use, but at that time, it was more accepted in our society than it is now.

I am emphasizing the limitations of using self-reports to measure recent drug use, because persons are more likely to report using illegal drugs 6 months or 1 year ago than they are to report use in the past 3 days. People fear greater consequences if they admit to currently using an illegal drug, rather than use in the more distant past.

Now, some scientists are quick to play down the implications of studies of the validity of self-reports by arrestees because they claim that persons under the criminal justice supervision are least likely to report their drug use, regardless of the guarantees of confidentiality that researchers give them. However, there is extensive evidence which is in my written testimony that underreporting is a problem in surveys of all types of populations. It could be argued that persons in contact with the criminal justice system, the homeless and employees, may have significant reasons for underreporting their drug use, even in confidential research interviews, as the other research I am not going over shows.

One might expect, however, that drug abuse treatment clients would find little reason to conceal their drug use, especially in admission to treatment. Assessment and diagnostic tools generally rely upon the person's accurate reporting of recent drug use and associated problems. Moreover, treatment evaluation studies often depend on self-report measures of drug use at intake and at followup to assess treatment outcomes. Systematic differences in underreporting of drug use would greatly overestimate the beneficial results of drug treatment. The evidence suggests, however, even drug abuse treatment clients may systematically underreport their recent drug use.

So the recent literature raises important questions regarding the validity of self-report measures of drug use in a variety of contexts, and it can no longer be assumed research subjects will accurately report on their relations to drug use when queried during confidential research interviews.

I have three recommendations to the subcommittee. First, all federally funded studies of illegal drug use should assess drug use by the analysis of biological specimens as well as by self-reports, whenever feasible. Such a procedure is especially important in evaluating treatment outcome. Without biological testing, it is vir-

tually impossible for researchers and policymakers to be certain of the accuracy of changes in illegal drug use after treatment.

Second, the GAO reported measurement of drug use recommended that the national surveys of students and household members utilized biological measures of recent drug use to assess the validity of self-reported illegal drug use. A soon-to-be-released study that used the methodology of the national household survey and also collected hair samples to measure drug use found much higher estimates of cocaine use from the hair tests than from the interview responses. It is indefensible that federally funded national surveys have not conducted validity studies using biological specimens. This subcommittee should see to it that these expensive drug surveys not rely solely upon respondents to report their illegal drug use. National drug policy must be built upon the most accurate data we can obtain.

Third, the Federal Government should foster development and testing of new technologies to measure drug use. Hair analysis has been found by some researchers to offer advantages in detecting the use of drugs such as cocaine and heroin. If further research can confirm hair analysis' potential for longer periods of detection, compared with urinalysis, and reduced vulnerability to contamination, hair analysis may offer researchers a new tool for improving the measurement of illegal drug use. The ill-advised actions of governmental personnel to retard and inhibit the research uses of hair analysis techniques should be investigated. I have been affiliated with several studies that propose to use hair analysis and had been approved for funding by peer review panels, only to receive award letters that specifically prohibited spending any of the Federal funds on the hair analysis. Such ill-advised actions prevent scientists from developing and testing new methods for measuring drug use.

Thank you, Mr. Chairman, and members of the subcommittee. I welcome your comments and questions and I salute your efforts to improve the methodology used to evaluate the efficacy of drug treatment.

Mr. MICA. Thank you, Dr. Wish.

[The prepared statement of Mr. Wish follows:]

Thank you, Mr Chairman and members of the Subcommittee, for this opportunity to address the Government Reform and Oversight's Subcommittee on National Security, International Affairs, and Criminal Justice. I speak today as a psychologist with over 25 years of experience in substance abuse research. During my graduate and postdoctoral training in the 1970's, I had the privilege of working with Dr. Lee N. Robins in the Department of Psychiatry at the Washington University School of Medicine in St. Louis. I was an analyst on her classic follow-up study of drug use in Vietnam veterans. That study showed the dramatic and unexpected rates of remission from heroin dependence among Army enlisted men after they returned to the United States. In the 1980's, I directed studies of drug use and crime among arrestees in Washington, D.C., of marijuana users in treatment in Manhattan, and of heroin and cocaine abusing adult criminals in East Harlem.

In 1984, I received a grant from the National Institute of Justice to assess drug use in more than 6,000 persons recently arrested and processed in the Manhattan Central Booking facility. That study collected voluntary and confidential urine specimens from almost 5,000 arrestees. The findings showed the high prevalence of cocaine use among arrestees; 42 percent tested positive by urinalysis. That study also revealed the considerable underdetection of drug use by thin layer chromatography, the urinalysis technique routinely used at that time to screen offenders and treatment program clients for drug use, compared with the newly developed and more sensitive immunoassay tests. The study also showed that many more arrestees tested positive for cocaine metabolite than admitted recent use of the drug in the confidential research interviews. These findings provided indisputable evidence, subsequently replicated in numerous studies, that researchers, let alone criminal justice personnel (Wish et al. 1986), would greatly

underestimate current drug use in a detainee population if they relied solely on people to accurately report their current use of illegal drugs.

The results from the Manhattan arrestee study led the National Institute of Justice (NIJ) to sponsor me to become a Visiting Fellow at NIJ. In November 1986, I joined NIJ to launch the Drug Use Forecasting Program (DUF, recently renamed ADAM), that is currently operating in 23 sites across the United States. Each quarter, the DUF program measures drug use by urinalysis tests and interviews with new samples of arrestees. The program has consistently found that the urine tests detect two to four times as many drug users as do the self-reports from the anonymous interviews with the arrestees. After leaving NIJ in 1990, I took over the Directorship of a new academic research center, CESAR, at the University of Maryland in College Park. CESAR staff have conducted a number of studies of drug use, treatment need and treatment outcomes.

My thesis today is simple. A growing body of research studies provide convincing evidence, that in the 1990's, researchers must rely on more than self-reports to estimate recent illegal drug use. I emphasize "in the 1990's," because we live in a period of zero tolerance of any illegal drug use and even of the use of some legal drugs, like tobacco products and alcohol. It is difficult to believe today, that in 1974 Dr. Peter Bourne, who later became President Carter's drug policy advisor, said that he could not understand DEA's efforts to interdict cocaine, "the most benign of illicit drugs currently in widespread use (reprinted in Musto 1989, p. 4)." How different a society we live in today, where our children are bombarded with commercials warning them of the consequences from using illegal drugs! Our society's increasing stigmatization of illegal drug use affects survey respondent's willingness to report illegal drug use and explains

why researchers find more underreporting of drug use in studies conducted today than in studies conducted when drug use was considered more benign.

I am emphasizing the limitations of using self-reports to measure recent drug use, because persons are more likely to report using an illegal drug six months or a year ago, than they are to report use in the past three days. People fear greater consequences if they admit to currently using an illegal drug, rather than use in the more distant past.

Some scientists are quick to play down the implications of studies of the validity of self-reports by arrestees, because they claim that persons under criminal justice supervision are least likely to report their drug use, regardless of the guarantees of confidentiality that researchers give them. However, there is extensive evidence that underreporting is a problem in surveys of all types of populations (Wish et al. 1997):

Of the patients seeking treatment in a medical clinic who tested positive for cocaine by urinalysis, only 28 percent reported recent use of the drug in the nurse-administered medical intake interview (McNagy and Parker 1992).

Marques et al. (1993) studied a sample of infants and their postpartum mothers using interviews and urine and hair analyses. They found that while the cocaine levels in infant hair were correlated with analyses of maternal urine ($r = .28$) and hair ($r = .43$), the maternal self-reports of cocaine use did not correlate ($r = .06$) with the infant hair results. The authors concluded that self-reported drug use information routinely collected by interviewers should be interpreted cautiously.

Cook et al. (1995;1997) found that less than one half of the employees of a steel manufacturing plant who tested positive by urine or hair analysis reported their drug use in anonymous research interviews or group-administered questionnaires. The largest amount of underreporting was found for cocaine/crack use.

A study of occupants of shelters and residents of single-occupancy hotels in New York City and State found that only one third of the persons who tested positive for cocaine by hair analysis reported ever using the drug in the telephone research interview, even though all had been informed that they would be tested (Appel 1995).

Falck et al. (1992) reported considerable underreporting of cocaine and opiate use in their study of a sample of not-in-treatment, nonincarcerated IV drug users who were not given advance notice of the urine test.

National Opinion Research Center researchers recruited adult resident volunteers from the neighborhoods around the University of Chicago to participate in a "survey on health issues" (Tourangeau et al. 1997). Persons were randomly assigned to the (fake) lie detector or control condition. The researchers found that persons who believed they were being monitored by a lie detector were more likely to report sensitive behaviors such as lifetime marijuana or cocaine use, and drinking and driving, than the control subjects interviewed without the lie detector. For example, lie detector subjects were much more likely than control subjects to report ever smoking "pot" (71 percent vs. 57 percent) or using cocaine (44 percent vs. 26 percent).

It could be argued that persons in contact with the criminal justice system, the homeless, and employees may have significant reasons for underreporting their drug use, even in confidential research interviews. One might expect, however, that drug abuse treatment clients would find little reason to conceal their drug use, especially at admission to treatment. Assessment and diagnostic tools generally rely upon the person's accurate reporting of recent drug use and associated problems. Moreover, treatment evaluation studies often depend on self-report measures of drug use at intake and at follow-up to assess treatment outcomes. Systematic differences in underreporting of drug use would greatly overestimate the beneficial results of drug treatment. The evidence suggests, however, that even drug abuse treatment clients may systematically underreport their drug use.

In a study of persons receiving treatment at methadone programs, Magura et al. (1987) found that only 35 percent of those who tested positive for opiates by an immunoassay urinalysis test (EMIT) reported using the drug in the prior 30 days. Reporting was higher for cocaine (85 percent) and benzodiazepines (61 percent). These results underestimated the level of potential underreporting, however, because persons were classified as having used a drug if they reported current use or use in the past 30 days, rather than use in the past 2 or 3 days, the period to which the urine tests were sensitive. In addition, the fact that in 31 percent of the cases the interviews were completed within 28 days after the urine sample was obtained, makes

the results difficult to interpret.

A comparison of the urinalysis results and self-reported drug use for clients in the Treatment Outcome Prospective Study (TOPS) 24 months after treatment found that only 33 percent of those positive for opiates reported using heroin in the prior three days (Research Triangle Institute 1994). That study also found that only 40 percent of the cocaine-positive clients reported using the drug in the prior three days

.

The *Early Retrospective Study of Cocaine Treatment Outcomes*, a study of clients receiving treatment for cocaine at a subset of Drug Abuse Treatment Outcome Study (DATOS) programs, found that only 26 percent of the 109 clients who tested positive for cocaine by urinalysis at follow-up 12 months after treatment reported using the drug in the prior 72 hours. Less than one half (43 percent) of the cocaine-positive clients admitted using the drug in the prior two weeks. Even when the researchers expanded their measure to compare the concordance between any drug-positive urine test and a self-report of the use of any drug in the prior 72 hours, they reported, "but still two-thirds of those who tested positive for any drug did not report use of any drug in the past 72 hours" (Research Triangle Institute 1994, p. 4-10; see also Poole et al. 1996).

Magura et al. (1992) obtained interview, urine, and hair test information to investigate the validity of hair analysis among clients receiving methadone treatment. They found that 81 percent of clients positive for cocaine by urinalysis and 73 percent positive by hair analysis reported using the drug in the confidential research interview. The numbers were smaller for heroin, however--57 percent and 64 percent, respectively.

Hinden et al. (1994) found that most of the persons who tested positive by hair analysis for heroin (96 percent) or cocaine (89 percent) at the inception of residential treatment had reported their use of these drugs during the admission interview. However, at the post-treatment interview, only 67 percent of those positive for heroin and 51 percent of those positive for cocaine reported using the drugs. The authors speculated that persons may be less likely to report drug use after treatment or when not in the protected treatment environment. Similar concerns have been raised by Magura and Kang (1995) and Wish et al. (1997).

Sowder et al. (1993) reported that clients who have received treatment may be less likely to report drug use at a follow-up interview than control subjects who received no treatment. Persons who received treatment may not want to admit to the interviewer that they have relapsed to drug use. Persons may not want to admit that they wasted their time in treatment! Such a bias could make the group that received treatment appear better at follow-up than control subjects, simply because of differences in self-reporting in the two groups.

In summary, the recent research literature raises important questions regarding the validity of self-report measures of drug use in a variety of contexts. It can no longer be

assumed that research subjects will accurately report on their illicit drug use when queried during confidential research interviews. The accuracy of the information obtained will vary depending upon the research context, the type of respondents and even the type of drug use being measured. This does not mean that the findings of treatment evaluations that rely solely on self-reports of drug use are inaccurate. My point is that unless researchers use biological assays, such as urine or hair analyses, along with self-reports when attempting to measure the recent use of illegal drugs, the findings are suspect.

Recommendations

1. All federally funded studies of illegal drug use should assess drug use by the analysis of biological specimens as well as by self-reports, wherever feasible. Such a procedure is especially important in evaluating treatment outcome. Without biological testing, it is virtually impossible for researchers and policymakers to be certain of the accuracy of changes in illegal drug use after treatment.

2. The GAO report on measurement of drug use recommended (General Accounting Office 1993) that the national surveys of students (Monitoring the Future) and household members (National Household Survey) utilize biological measures of recent drug use to assess the validity of self-reported illegal drug use. A soon-to-be-released study that used the methodology of the National Household Survey and also collected hair samples to measure drug use, found much higher estimates of cocaine use from the hair tests than from the interview responses. It is indefensible that federally funded national surveys have not conducted validity studies using biological specimens. This Subcommittee should see to it that these expensive drug surveys not rely solely upon respondents to report their illegal drug use. National drug

policy must be built upon the most accurate data we can obtain.

3. The federal government should foster the development and testing of new technologies to measure drug use. Hair analysis has been found by some researchers to offer advantages in detecting the use of drugs such as cocaine and heroin (see review by Wish et al. 1997). If further research can confirm hair analysis' potential for longer periods of detection (compared with urinalysis) and reduced vulnerability to contamination, hair analysis may offer researchers a new tool for improving the measurement of illegal drug use. The ill-advised actions of governmental personnel to retard and inhibit the research uses of hair analysis techniques should be investigated. I have been affiliated with several studies that proposed to use hair analysis and had been approved for funding by peer review panels, only to receive award letters that specifically prohibited spending any of the federal funds on hair tests! Such ill-advised actions prevent scientists from developing and testing new methods for measuring drug use.

Thank you Mr. Chairman and members of the Subcommittee. I welcome your comments and questions. I salute you for your important efforts to improve the methodology used to evaluate the efficacy of drug treatment.

REFERENCES

Appel, P.W. "Substance Abuse Among Adults in Transient Housing in New York State: Validation of Self-Report by Use of Hair Analysis." New York State Office of Alcoholism and Substance Abuse Services and Research Institute on Addictions, 1995.

Cook, R.F.; Bernstein, A.D.; Arrington, T.L.; Andrews, C.M. Methods for assessing drug use prevalence in the workplace: A comparison of self-report, urinalysis and hair analysis. In Harrison, L. and Hughes, A., eds. *The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates.* NIDA Research Monograph 167, NIH Publication No. 97-4147. Rockville, Md.: National Institute on Drug Abuse, 1997:247-272.

Cook, R.F.; Bernstein, A.D.; Arrington, T.L.; Andrews, C.M.; and Marshall, G.A. Methods for assessing drug use prevalence in the workplace: A comparison of self-report, urinalysis and hair analysis. *Int J Addict* 30(4):403-426, 1995.

Falck, R.; Siegel, H.A.; Forney, M.A.; Wang, J.; and Carlson, R.G. The validity of injection drug users' self-reported use of opiates and cocaine. *J Drug Issues* 22(4):823-832, 1992.

General Accounting Office. *Drug Use Measurement.* Washington, DC: General Accounting Office, 1993.

Hinden, R., McCusker, J.; Vickers-Lahti, M.; Bigelow, C.; Garfield, F.; and Lewis, B. Radioimmunoassay of hair for determination of cocaine, heroin and marijuana exposure: Comparison with self-report. *Int J Addict* 29(6):771-789, 1994.

Magura, S., and Kang, S.Y. *Validity of Self-Reported Drug Use in High Risk Populations: A Meta-Analytic Review.* New York: National Development and Research Institute, Inc., 1995.

Magura, S.; Goldsmith, D.; Casriel, C.; Goldstein, P.J.; and Lipton, D.S. The validity of methadone clients' self reported drug use. *Int J Addict* 22(8):727-749, 1987.

Magura, S.; Freeman, R.; Siddiqi, Q.; and Lipton, D.S. The validity of hair analysis for detecting cocaine and heroin use among addicts. *Int J Addict* 27(1):54-69, 1992.

Marques, P.R.; Tippetts, A.S.; and Branch, D.G. Cocaine in the hair of mother-infant pairs:

Quantitative analysis and correlations with urine measures and self-report. *Am J Drug Alcohol Abuse* 19(2):159-175, 1993.

McNagy, S.E., and Parker, R.M. High prevalence of recent cocaine use and the unreliability of patient self-report in an inner-city walk-in clinic. *JAMA* 267(8):1106-1108, 1992.

Musto, D.F. The history of American Drug Control. *Update on Law-related Education* 13(2):3-56, 1989.

Poole, W.K.; Flynn, P.M.; Rao, A.V.; Cooley, P.C. Estimating the prevalence of drug use from self-reports in a cohort for which biologic data are available for a subsample. *American J Epidemiology*144(4):413-420, 1996.

Research Triangle Institute. "Early Retrospective Study of Cocaine Treatment Outcomes, Overview and Findings." Draft technical report no. 1, vol. I, submitted to the National Institute on Drug Abuse. Research Triangle Park, N.C.: Research Triangle Institute, 1994.

Sowder,B.J , Beschner, G.M.; Ergh, T.; Wish, A.; Wish, E.D.; Zhang, Y.; Sowder, J. "Waiting List Community Intervention Project." Summary report submitted to the National Institute on Drug Abuse. Bethesda, Md.: Nova Research Corporation, 1993.

Tourangeau. R.; Smith, T.W.; Rasinski, K.A. Motivation to report sensitive behaviors on surveys: Evidence from a bogus pipeline experiment. *Journal of Applied Psychology* 27(3):209-222, 1997.

Wish, E.D.; Cuadrado, M.; Martorana, J. Estimates of drug use in intensive supervision probationers: Results from a pilot study. *Federal Probation* 1986:4-16.

Wish, E.D.; Hoffman, J.A.; and Nemes, S. The validity of self-reports of drug use at treatment admission and followup: Comparisons with urinalysis and hair assays. In Harrison, L. and Hughes, A., eds. *The Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates.* NIDA Research Monograph 167, NIH Publication No. 97-4147 Rockville, Md.: National Institute on Drug Abuse, 1997:200-226.

UNIVERSITY OF MARYLAND

CENTER FOR SUBSTANCE ABUSE RESEARCH

Eric D. Wish, Ph.D.
Director of CESAR and Associate Professor, Department of Criminology and Criminal Justice, University of Maryland, College Park

RECENT EXPERIENCE

Dr. Wish is currently the Principal Investigator of the evaluation of the D.C. Drug Treatment Initiative Experiment sponsored by CSAT and NIDA. This study is conducting follow-up interviews of over 400 persons randomly assigned to receive standard or abbreviated residential treatment in a therapeutic community. Dr. Wish is also the Principal Investigator of a CSAT-funded family of studies designed to assess treatment need among various segments of the Maryland population, including households residents and adult and juvenile arrestees. He is also the Principal Investigaor of the evaluation of a CSAT-sponsored evaluation of a residential therapeutic community for women and their children. Dr. Wish oversees the production of the weekly CESAR FAX and CSAT by FAX, disseminated to a diverse audience nationwide.

SUMMARY OF PROFESSIONAL EXPERIENCE

Dr. Wish began his training in the substance abuse field as an NIMH Drugs and Addictions Trainee in 1972. Upon completing his Ph.D. in Social Psychology at Washington University, Dr. Wish was awarded a NIDA Post-Doctoral Fellowship in psychiatric epidemiology under the sponsorship of Dr. Lee N. Robins. During that time, Dr. Wish was chief analyst for the NIDA-funded follow-up study of Vietnam veterans and nonveterans.

Dr. Wish was subsequently awarded a NIDA grant to study drug abuse clients who have marijuana as a primary drug of abuse.

In 1983 Dr. Wish launched a study of drug use in over 6,000 persons arrested in Manhattan in order to analyze the relationship of drug use at arrest to pretrial misbehavior. This study led to the development of the national Drug Use Forecasting (DUF) program for the National Institute of Justice.

Upon joining the University of Maryland in 1990, Dr. Wish became Director of the Center for Substance Abuse Research (CESAR), and has attracted a staff of over 20 persons. CESAR has a national reputation for rigorous research in what has been called applied epidemiology, the tracking of drug use in various populations and the presentation of findings in a manner that is useful to a wide range of audiences.

Dr. Wish has published widely and spoken around the world about many topics, including the measurement of drug use, the relationship of drug use to crime, the validity of self-reports of drug use, and drug policy.

SUMMARY OF EDUCATIONAL EXPERIENCE

Ph.D., Washington University, St. Louis, Social Psychology, 1977

B.S., Cum Laude, University of Massachusetts, Amherst, 1968

Mr. MICA. Now I would like to recognize Mr. Raymond Soucek—or Soucek?

Mr. SOUCEK. Soucek.

Mr. MICA. Soucek. I destroyed that, I apologize—who is president of the Haymarket Center.

You are welcome, sir.

Mr. SOUCEK. Thank you, Mr. Chairman, for providing Haymarket Center with this opportunity to present testimony. My oral statement is an abbreviated version of my written testimony, and I ask that it be placed into the record.

Mr. MICA. Without objection, so ordered.

Mr. SOUCEK. I serve as president of Haymarket, a comprehensive substance abuse treatment center, located on the near west side of Chicago. It was founded in 1975 by Monsignor Ignatius McDermott, a Catholic priest.

Over the past 23 years, we have grown into the largest treatment center in the city of Chicago and the third largest in the State of Illinois. We offer comprehensive and integrated treatment services to an average of 13,000 unduplicated clients annually. We are pleased that Congressman Hastert chose to visit our facility earlier this month.

Accompanying me today is Ms. Bettie Foley, associate director of Haymarket. Bettie is an expert on two special substance abuse populations within the treatment field—the nonviolent offender and pregnant women and postpartum women. She is available to answer any questions that you or your colleagues may have. She will also be providing testimony tomorrow.

Haymarket Center is a nonsectarian, nondenominational, not-for-profit organization. We consider our treatment approach, however, to be faith-based, since we believe that spirituality plays a role in recovery. Spirituality in our programs is focused on our efforts to reunite and reconnect recovering addicts with aspects and relationships in their lives which they have been separated from because of their addiction.

This approach, most commonly employed through our integrating "12-step" principles into our treatment programs, focuses on reconnecting our clients to themselves and to others who were important in their lives before the substance abuse took control over their lives.

We at Haymarket have developed several unique programs to address the needs of high-risk populations throughout our 23 years. We refer to this as a "continuum of care." This continuum is the integration of drug abuse prevention, drug abuse treatment, medical and health services, day care, parent training, vocational education, job placement, and screening for domestic violence and gambling addiction.

The continuum provides clients with a comprehensive and integrated range of treatment programs. Clients are encouraged to address all issues related to their addiction as they progress along the continuum of care.

Clients are informed that spirituality through faith can be an important factor in their efforts toward total recovery. In order to ensure that each Haymarket client receives specific and individualized services, we continuously enhance the development and imple-

mentation of programs for men, women and families that are based on gender differences, cultural sensitivity and the ever-changing demands for services.

Our mission is to return recovering addicts to society in a drug-free state, but also in a condition that is physically, mentally, and spiritually healthy, thus enabling them to become more productive members of society. Our model of the integration of comprehensive services enables us to meet that goal. We feel that it is crucial to stress today that treatment works, and that investing in innovative and effective substance abuse treatment methods is a crucial component of the Federal Government's drug control policy.

Along with prevention, treatment is an essential component in any demand reduction strategy. Based on our experience with the front line fight against substance abuse, we believe treatment is the most cost effective way to combat addiction and drug-related crime. This belief is backed by extensive research which confirms that treatment is cost effective. Unfortunately, less than one-third of the Federal drug budget is devoted to reducing the demand for drugs and treatment is too often overlooked.

We are pleased that the House Appropriations Committee recently supported a bill providing increased funding for the programs of the Substance Abuse and Mental Health Service Administration. We ask that the members of this subcommittee support these funding increases for SAMHSA. As good stewards of Federal funding, the treatment community can continue to improve services by equipping itself with a better understanding of which treatment methods are most effective with which subgroups of abusers and addicts. For example, program models which were developed to treat the white male population may not be directly transferrable to other groups such as black female pregnant women.

Finally, the GAO study published in March of this year verifies that treatment consistently reduces drug use and crime, but current data collection techniques do not allow accurate measurement of the extent to which treatment reduces the use of illegal drugs. One Haymarket program, however, has recently been evaluated to demonstrate results.

In 1995, Haymarket received a grant from the Center for Substance Abuse Treatment to implement and evaluate comprehensive residential treatment, childcare and after care programs for chemically dependent women and their children. This program called Athey Hall also had a 2-year evaluation component. The evaluation component was conducted by CSAT in the fall of 1997 and concluded with a report on the status of clients who successfully completed the Athey Hall program.

Through interviews with clients, family members and close personnel contacts, and also with the use of random urine screenings, the evaluators determined that the recovery rate for the discharged clients from Athey Hall's first 2 years was approximately 70 percent. Even in the worst case, with all nonreporting clients assumed to have recidivised, this recovery rate exceeds the norm for Illinois. The majority of these recovering clients maintain jobs, have gone back to school, have received custody of their children, and have established independent housing for themselves and their families.

With us today we have several copies of this and other research which confirms that treatment works and it is cost effective. We would be happy to share these reports with the members of the subcommittee and ask that they be included in the hearing record.

Mr. Chairman, and the members of the subcommittee, as Congress determines the direction and best use of Federal resources and the scope of policy with regard to our Nation's substance abuse epidemic, we urge you to recognize treatment as a vital and effective component of the overall war on drugs.

Knowledge and implementation of comprehensive and effective treatment practices is the most successful strategy treatment providers can employ in our mission to move people away from dependency and toward becoming productive members of society. We hope that you will recognize the value of treatment as you develop new legislation to implement drug control strategies. Thank you for the opportunity to testify today.

Ms. Foley and I would be happy to answer any questions that you may have.

[The prepared statement of Mr. Soucek follows:]

Thank you, Chairman Hastert, for providing Haymarket Center with this opportunity to present testimony before your subcommittee.

I serve as President of Haymarket, a comprehensive substance abuse treatment center on the Near West Side of Chicago, founded in 1975 by Monsignor Ignatius McDermott. Over the past twenty-three years we have grown into the largest treatment center in the City of Chicago, and the third largest in the State of Illinois. We offer comprehensive and integrated treatment services to an average of 13,000 clients annually.

Accompanying me today is Bettie Foley, Associate Director of Haymarket. Bettie is an expert with respect to two special substance abusing populations within the treatment field – the nonviolent offender and pregnant women. She is available to answer any questions the Subcommittee might have with regard to these two critical issues.

Though we are a non-sectarian, non-denominational, not-for-profit organization, we at Haymarket consider our treatment approach to be *faith-based* since we believe that spirituality definitely plays a role in recovery. Spirituality in our programs is focused on our efforts to reunite and reconnect recovering addicts with aspects and relationships in their lives from which they have been separated because of their addiction. This approach, most commonly employed through our "Twelve Step" programs, addresses the nature of the person and focuses on reconnecting our clients to themselves and to others who were important in their lives before the substance abuse took control.

We at Haymarket have developed several unique programs to address the needs of high-risk populations throughout our 23 years. Still, we acknowledge a need to continue to refine what we

refer to as a "continuum of care" for our clients. This "continuum" is the integration of drug abuse prevention, drug abuse treatment, medical and health services including HIV/AIDS, day care, parent training, vocational education, job placement and screening for domestic violence and gambling addiction. The continuum provides clients with a comprehensive and integrated range of treatment programs. Clients are encouraged to address their issues as they progress along the continuum of care, and are reminded that spirituality, through faith in a power greater than themselves, can be a crucial factor in their efforts towards total recovery.

Our clients are immediately assessed upon admittance to our facilities and are referred, depending upon physical and mental status, to the most appropriate treatment from our array of programs. In order to ensure that each addict receives the specific and individualized services he or she may require, we continuously enhance the development and implementation of programs for men, women and families that are based on gender specificity, cultural sensitivity and the ever changing demand for services.

In addition to detoxification and residential treatment, Haymarket offers specialized residential and outpatient treatment programs for pregnant, postpartum and parenting women. We provide an on-site preventative health care clinic that is part of the Healthy Start network and child care/licensed day care programs. Our mission is to return recovering addicts to society in a drug-free state but also in a condition that is physically, mentally and spiritually healthy and thus enabling them to become more productive members of society. Our model of the integration of comprehensive services enables us to meet this goal.

We feel that it is crucial to stress today that *treatment works*, and that investing in innovative and effective substance abuse treatment methods is a crucial component of the Federal government's

drug control policy. Along with prevention, treatment is an essential component of any demand reduction strategy. Based on our experience with the front-line fight against substance abuse, we believe treatment is the most cost-effective way to combat addiction and drug-related crime. This belief is backed by extensive research which confirms that treatment is cost-effective. Unfortunately, less than one-third of the federal drug budget is devoted to reducing the demand for drugs, and treatment is too often overlooked.

We believe that these limited resources ought to be targeted towards high-risk populations and towards programs which will provide the greatest return on the federal investment. In order for the treatment community to do a better job with federal resources, policy related to treatment and prevention must become more coherent and better coordinated, and post-treatment outcomes must be stressed.

For this coordination to occur, the treatment community needs to equip itself with a better understanding of which treatment methods are most effective with which subgroups of abusers and addicts. For example, program models which were developed to treat a white, male population may not be either gender specific nor culturally sensitive and therefore not directly transferable to other groups like pregnant women.

Finally, studies continue to show that which Haymarket and other treatment providers already know: *treatment works*. The GAO study, published in March this year, verified that treatment consistently reduces drug use and crime, but current data collection techniques do not allow accurate measurement of the extent to which treatment reduces the use of illegal drugs. One Haymarket program, however, has recently been evaluated to demonstrate such results.

In 1995, Haymarket received a grant from the Center for Substance Abuse Treatment (CSAT), to implement and evaluate a comprehensive residential treatment, childcare and aftercare program for chemically dependent women and their children. The Athey Hall program's two-year evaluation, conducted by CSAT in Fall 1997, provides factual evidence to support that Haymarket's comprehensive approach to treatment, including the availability of faith and spirituality as components, results in outstanding recovery and placement figures.

The evaluation concluded with a report on the status of clients who had successfully completed the Athey Hall program. The program successfully discharged, or graduated, 64.6 percent of its clients during the first two years. The evaluation team was successful in reaching and surveying more than two thirds of these clients. Of them, approximately sixty percent were working, and about one-third were pursuing a G.E.D. or other training. Approximately one half were living independently, and two thirds were attending community self-help groups. Less than one half were receiving welfare payments or food stamps.

Through interviews with clients, family members and close personal contacts, and with the help of random urine screenings, the evaluators determined that the recidivism rate for discharged clients from Athey Hall's first two years ranged from 20 - 43 percent. Even at worst case, with all non-reporting clients assumed to have recidivised, this recidivism rate still falls below the Illinois average.

With us today we have several copies of other research which confirms that treatment works and is cost-effective. We would be happy to share these with members of the Subcommittee.

Mr. Chairman and Members of the Subcommittee, as Congress determines the direction and best use of federal resources and the scope of policy with regard to our nation's substance abuse epidemic, we urge you to recognize treatment as a vital and effective component of the overall war on drugs. Knowledge and implementation of comprehensive and effective treatment practices is the *most* successful strategy treatment providers can employ in our mission to move people away from dependency and toward becoming productive members of society.

Thank you for the opportunity to testify today. Ms. Foley and I would be happy to answer any questions you may have.

Substance Abuse and Crime in Illinois: What the Research Tells Us

TASC Research
and Information Systems
James Swartz, Ph.D., Director

Extracted from "A Public Safety Partnership"
©TASC, February 1998

1500 N. Halsted St.
Chicago, IL 60622
Melody M. Heaps, President

What's Inside

The facts and figures contained in this report highlight the destructive impact of substance abuse on crime in our society and demonstrate how treatment has been effective in reducing some of the negative behaviors commonly associated with substance abuse

Executive Summary — Page 3

Substance Abuse & Crime: an exploration of the impact of substance abuse on the criminal justice system and other social concerns — Pages 4-11

Substance Abuse Treatment: how different treatment programs have proven effective in reducing the negative social aspects of substance abuse — Pages 12-17

TASC in Illinois

TASC (Treatment Alternatives for Safe Communities) is a private, not-for-profit organization whose primary goal is to break the vicious cycle of drug abuse and criminal activity among non-violent, drug-involved offenders by linking the legal sanctions of the criminal justice system with drug treatment. There are eleven TASC offices throughout the state and services are available in every judicial circuit in Illinois.

TASC links the criminal justice system to community-based substance abuse treatment by providing:

- **Intervention** to identify substance-abusing offenders in need of treatment
- **Assessment** of the offenders' level of substance abuse, need for treatment, and motivation and cooperation for treatment
- **Service Planning** for the individual needs of each client, considering such factors as the client's problem, ancillary services required and the availability of treatment resources
- **Placement** of offenders into the appropriate type and level of treatment, as well as referral to ancillary services
- **Monitoring** of offenders throughout treatment
- **Reporting** to the court system on client progress/failure

TASC uses its unique case management model to reach other critical populations, including:

- delinquent juveniles
- youth in the child welfare system
- HIV infected individuals
- substance-abusing welfare recipients

For the complete "Public Safety Partnership" from which the following summaries are extracted, please contact TASC's Communications Office at (312) 573-8225.

© 1998 TASC, Inc.

Executive Summary

Substance Abuse & Crime

The link between drug use and crime is inextricable. A study of men and women arrested in Illinois revealed that over 60% had been using an illicit drug near the time of their arrest. Within Chicago, the usage rates are much worse, in some cases as high as 83% use prior to arrest. These figures indicate that Illinois has one of the worst drug use rates among arrestees in the country.

As the number of drug-related arrests skyrockets, so does the number of inmates with a history of or a current drug dependency. Over 50% of the men and over 60% of the women in the Illinois prison system have had a drug dependency at some point in their lives. The nature of addiction dictates that those inmates who don't receive substance abuse treatment are likely to return to society with their addictions intact - and the cycle of abuse and crime will continue.

The dramatic increase in juvenile crime and, in particular, juvenile violence has been accompanied by steady increases in drug use and abuse by juveniles. The number of juvenile arrestees nationwide testing positive for drugs has increased from 25% to 54% over the last four years. Increased drug use among America's children is prevalent in the general population of youth as well as juveniles arrested and/or detained by the criminal justice system. Drug abuse education, prevention and treatment programs for America's youth are components essential to reducing drug-related crime committed by children.

Substance abuse not only impacts criminal activity and juvenile justice, but domestic violence and public health as well. The majority of domestic violence perpetrators are substance abusers, and many victims of domestic violence are also alcohol or drug abusers. Additionally, aside from being a public health issue in itself, substance abuse is often implicated in the transmission of the AIDS virus. Intravenous drug use is the greatest vehicle for the transmission of HIV among women, and is the second-greatest among men. Substance abuse also leads to situations which put many abusers in much greater risk for contracting HIV, including unprotected sex, sex for drugs, and prostitution.

The Effectiveness of Substance Abuse Treatment

Despite the overwhelming nature of the problem, effective treatment interventions do exist. A 1996 Congressionally-mandated study demonstrated that, beyond decreasing participant's substance abuse rates, treatment also resulted in decreased rates of criminal activity and arrests, homelessness and high-risk sexual behavior. It also showed an increased rate of employment and improved overall health status for participants in the substance abuse process.

The most effective programs are those that not only provide treatment, but also help offenders make the transition from the criminal justice system to the community. In Chicago, the Cook County Jail's IMPACT program, which provides in-jail treatment as well as community-based follow-through, has significantly reduced rearrest rates of participants, dependent upon the length of time spent in treatment and participation in community-based treatment and aftercare.

Although there is abundant evidence that substance abuse treatment reduces both drug use and recidivism, resources to develop effective treatment systems are scarce. A large number of people needing treatment are unable to access it. To effect major change on drug-related crime in Illinois, interventions are needed to effectively *identify* those in need of substance abuse treatment, *match* their service needs with available resources, *treat* them with the appropriate type and level of care, *monitor* their progress and recovery, and successfully *reintegrate* them back into the community.

Substance Abuse & Crime

Since the early 1970's, substance abuse has had a devastating impact on the criminal justice system in the United States. Below are excerpts of recent research that demonstrate the effect of substance abuse on crime and our society.

330,000 Labeled Hard-Core Users

SOURCE
Chicago Tribune, December 11, 1997

Previous Casual and Hard-Core Drug Use Estimates in Cook County
Traditional studies used phone calls and mail-in surveys to gather data.

Current Hard-Core Drug Use Estimates in Cook County
The current study uses personal interviews and contacts to gather data.

Hard-Core User: **Used crack, powder cocaine or heroin on eight or more days during at least one of the preceding two months**

Research was conducted for the Office of National Drug Control Policy by Abt Associates, Inc. The study does not suggest that hard-core drug use has gone up, only that it is more widespread than many thought. Previous research methods substantially under-counted hard-core addicts.

"The findings are probably closer to the real picture than what is normally recorded. If these numbers are true, we have to look at providing a lot more treatment to hard-core drug users than is currently available."

- Joseph Califano, former U.S. health secretary who now heads the Center on Alcoholism and Substance Abuse in New York City

© 1998 TASC, Inc.

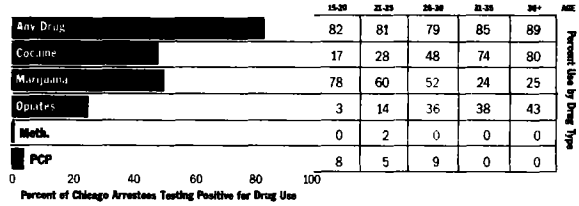
Alarming Rate of Drug Use Among Illinois Felony Arrestees

SOURCES
Illinois Drug Use Forecasting (DUF) Study, TASC Research 1996

Chicago Arrestee Drug Abuse Monitoring Program (ADAM), TASC Research 1997

In Chicago...

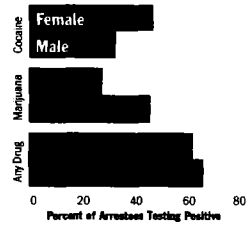
Drug use rates among Chicago male felony arrestees are high across age groups, but "harder" drugs become more prevalent as arrestees get older.



	15-20	21-25	26-30	31-35	36+	ARR.
Any Drug	82	81	79	85	89	
Cocaine	17	28	48	74	80	
Marijuana	78	60	52	24	25	
Opiates	3	14	36	38	43	
Meth.	0	2	0	0	0	
PCP	8	5	9	0	0	

Percent of male felony arrestees in Chicago who tested positive for recent drug use **83%**

In Illinois...



Most male and female felony arrestees in Illinois used illicit drugs in the days before their arrest.

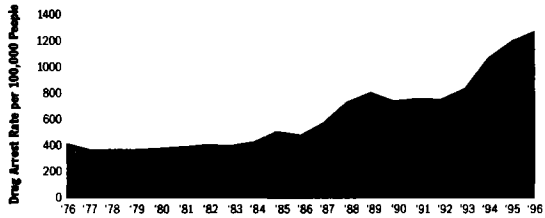
Percent of Illinois felony arrestees, male and female, who used an illicit drug near the time of their arrest **60%**

© 1998 TASC, Inc.

The Increase in Drug Arrests and Drug Offenders in Cook County and Illinois Is Overwhelming

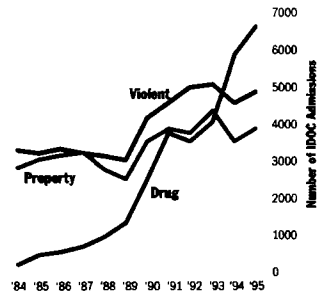
SOURCES
Illinois Criminal Justice Information Authority, 1997

After remaining steady for ten years, since 1984 the drug arrest rate in Cook County has tripled.



Increase in the ten years between 1976 and 1986	19%
Increase in the five years between 1986 and 1991	58%
Increase in the five years between 1991 and 1996	67%
Total increase from 1976 to 1996	202%

Between 1988 and 1996, IDOC admissions from Cook County for drug offenses have increased seven-fold, overtaking violent crimes in terms of numbers of admissions.

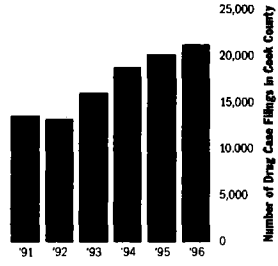


...continued on the next page

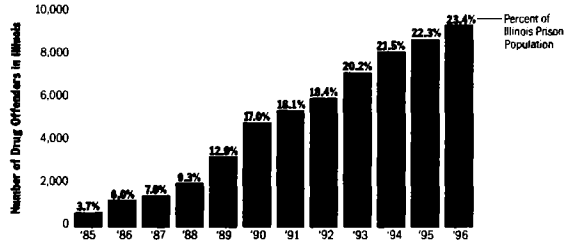
© 1998 TASC, Inc.

Substance Abuse & Crime

Drug cases now amount to more than 50% of all felonies charged in Cook County, and the total number is more than all felonies combined in any year before 1988.



There were almost 14 times as many drug offenders in Illinois prisons in 1996 as there were in 1985. During that same time period, the percent of state prisoners that were drug offenders rose from 3.7% to 23.4%



Number of Drug Offenders in Illinois Prisons in 1985	673	Number of Drug Offenders in Illinois Prisons in 1996	9,093
Percent Increase			**1250%**

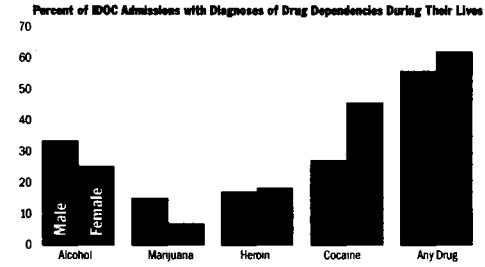
1995 National Average of Drug Offenders in State Prisons	4,498
Drug Offenders in Illinois Prisons in 1995	8,415

© 1998 TASC, Inc.

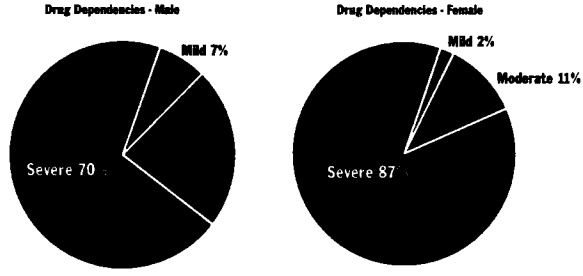
The Majority of Illinois Inmates Have Been Drug Dependent

SOURCE
Survey of Illinois Inmates
TASC Research 1994

Over half of both male and female inmates in Illinois report having a drug dependency at some point during their lives.



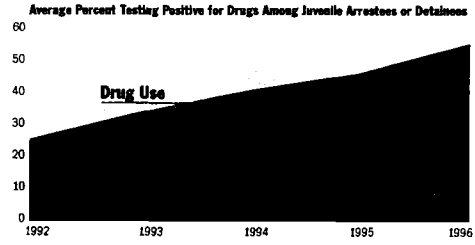
The overwhelming majority of both male and female inmates diagnosed with drug dependencies within the year before incarceration had dependencies classified as severe.



© 1998 TASC, Inc.

Substance Abuse, Juvenile Justice and Our Nation's Youth

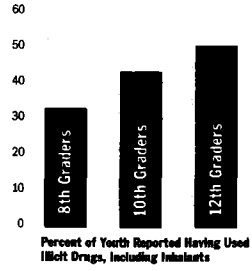
From 1992 to 1996, the number of juvenile arrestees or detainees testing positive for drug use has doubled. The number who test positive for marijuana use has tripled.



Percent of youth using marijuana before age 18 who go on to use cocaine **43%**

Greater likelihood that youth ages 12 to 17 who use marijuana will use cocaine, compared to non-marijuana users. **85 times**

Even among the general youth population, drug use rates are disturbing.



Percent of Youth Reported Having Used Illicit Drugs, Including Inhalants

© 1998 TASC, Inc.

Substance Abuse and Domestic Violence

The foremost element in distinguishing abused women from non-abused women is drug or alcohol use by the husband or boyfriend.

Percent of domestic violence cases involving alcohol or drug use — **50%**

Of the women currently being served by programs in Illinois that treat domestic violence issues, percent that were active substance abusers — **42%**

Of the women in domestic violence shelters after relationships of seven or more years, percent that reported that their partners had severe alcohol or drug problems — **85%**

The level of violence in domestic violence situations increases when either the batterer or victim has alcohol problems.

Of the domestic violence perpetrators killed by the women they battered, percent that were intoxicated every day or almost every day — **78%**

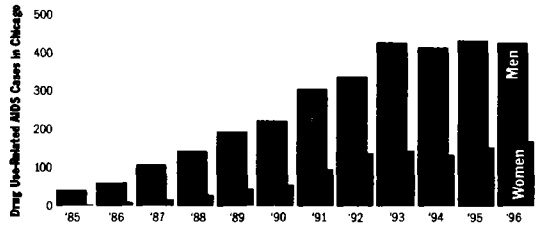
© 1998 TASC, Inc.

Substance Abuse & AIDS

Substance Abuse and AIDS in Illinois

In Chicago...

While the total number of AIDS cases has declined in the last few years, since 1988 transmission via injection drug use has actually increased and has consistently been the fastest growing percentage of new AIDS cases.



Many high-risk sexual activities are common among women who are substance-abusing offenders.

315 female drug offenders were surveyed in the Cook County Department of Corrections

20% had two or more sex partners in the previous month.

15% had traded sex for drugs in the previous month.

Between 3% and 10% had illnesses commonly associated with HIV infection and AIDS.

Substance abusing offenders are **3-11 times more likely to be HIV positive** than the general population.

Percent of new HIV cases in Chicago resulting from high-risk sexual activity or injection drug use. **90%**

*High-risk sexual activities include male-male sexual contact, prostitution, trading sex for drugs, multiple partners, and unprotected male-female sexual contact

In Illinois...

Percent of new HIV cases among men resulting from injection drug use. **28%**

Percent of new HIV cases among women resulting from injection drug use. **47%**

© 1998 TASC, Inc.

Substance Abuse Treatment

The Nature of Addiction

Addiction to drugs and/or alcohol is a complex physical and psychological condition. Most people who use alcohol or illicit drugs stop at the "recreational" stage but some people's use progresses to a problematic stage. Without appropriate intervention, their drug use may become habitual and develop into a physical and psychological dependency.

- Addiction is a chronic, relapsing condition that impairs the addicted person's ability to function in all aspects of their lives.
- Addiction is defined by compulsive use with loss of control, and continued use despite adverse consequences.
- Substance abuse affects not only the user, but also his/her family.

"Twenty years of neuroscience research have brought us to where we can actually see increases in specific brain activity that are linked to the experience of craving. If we can understand the mechanisms that cause craving in people addicted to cocaine or other drugs, more effective treatment strategies can be developed that counteract craving." - Alan Leshner, Ph.D., Director, National Institute on Drug Abuse

How Treatment Works

In most cases at least a year of treatment and self-help groups is needed before a person becomes secure in recovery. Frequently more than one attempt at treatment is needed. The likelihood of relapse is high, however, relapse can be prevented through effective treatment and aftercare services. Recovering alcoholics or addicts often participate in support groups for many years.

- Treatment focuses on personal reponsibility in coping with the illness.
- During treatment, recovering users:
  - receive information about drugs and addiction
  - are confronted with the negative consequences of their addiction
  - are forced to take responsibility for their actions
  - gain insight about their relationship with alcohol and other drugs
  - develop new patterns of thinking, feeling and behaving
  - work on the developmental tasks and skills needed to thrive in everyday life

"Thanks to the phenomenal progress in addiction research made in recent years, we now know more about drug abuse, and what to do about it, than ever before."
- Alan Leshner, Ph.D.

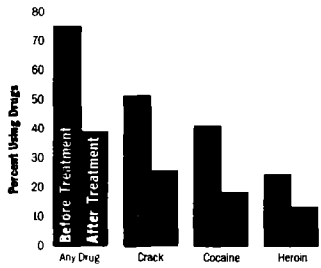
Despite the impact of drugs on crime, substance abuse treatment models have been shown to have remarkably decrease substance abuse and recidivism rates. On the following pages are excerpts of recent research that demonstrate the effectiveness of treatment and outline treatment interventions which have proven particularly successful.

© 1998 TASC, Inc.

Substance Abuse Treatment Effectiveness

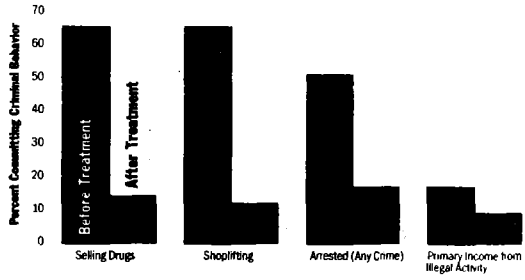
Treatment Significantly Reduces Criminal and Other Dangerous Behaviors

SOURCE
National Treatment Improvement Evaluation Study, 1996



In the 12 months following treatment, the number of participants using any drug or those using crack, cocaine and heroin dropped by as much as 50%.

In the 12 months following treatment, the number of participants committing specific crimes dropped as much as 82%.



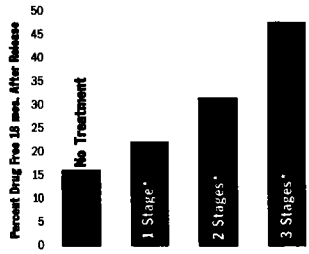
In addition to a reduction in drug use and criminal activity, HIV risk behaviors declined significantly, including a 56% drop in the exchange of sex for money or drugs.

© 1998 TASC, Inc.

Substance Abuse Treatment Effectiveness

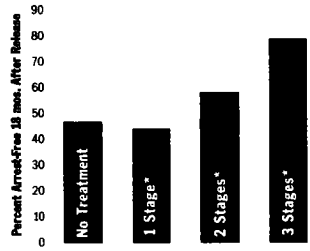
Multi-Stage Treatment is Most Effective in Reducing Drug Use and Recidivism

SOURCE
Center for Drug and Alcohol Studies
University of Delaware, 1997



47% of the participants who received three stages of treatment remained drug-free within 18 months of release, compared to only 16% of those who didn't receive any treatment.

1 stage = prison-based treatment only
2 stages = work-release and community treatment, but no prison-based treatment
3 stages = prison-based, work release and community-based treatment



77% of the participants who received prison-based treatment services, work release treatment services and community-based treatment services remained arrest-free within 18 months of release, compared to only 46% of those who didn't receive any treatment.

Average incidence of use for those participants in the three-stage group who did report drug use

Once a month or less

Average incidence of use for those participants receiving no treatment

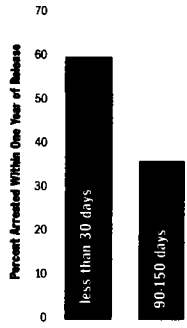
Several times per week

© 1998 TASC, Inc.

Illinois Jail and Community-Based Treatment Program Reduces Recidivism

Project IMPACT Study
James Swartz, Ph.D. 1996

Project IMPACT is a substance abuse treatment program in the Cook County Jail. The program includes not only intensive jail-based treatment, but also linkage to community-based services and case management of offenders after their release from jail.



Within one year of release, 58% of those who participated for less than 30 days had been arrested again. Of those who remained in the program 90-150 days, only 35% were arrested again.

Participants who also received community-based services had a recidivism rate 50% less than those who didn't receive community-based treatment.

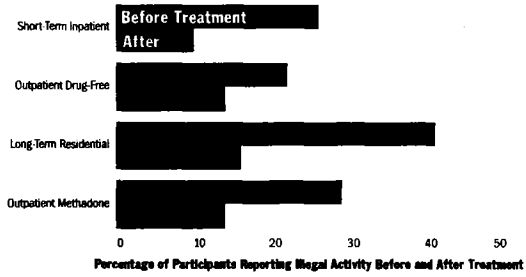
© 1998 TASC, Inc.

Substance Abuse Treatment Effectiveness

The Most Common Forms of Drug Abuse Treatment Aid in Reducing Criminal Activity

National Institute on Drug Abuse
Drug Abuse Treatment Outcome Study (DATOS), 1997

Drug abuse treatment was successful in reducing the number of participants committing illegal acts by as much as 60%.



The ability to keep participants in treatment was the largest determining factor in successful treatment outcomes.

The major predictors of how long participants would stay in treatment were:

- **high motivation**
- **no prior trouble with the law**
- **getting psychological counseling**
- **lack of any other severe psychological problems**
- **legal pressure to stay in treatment**

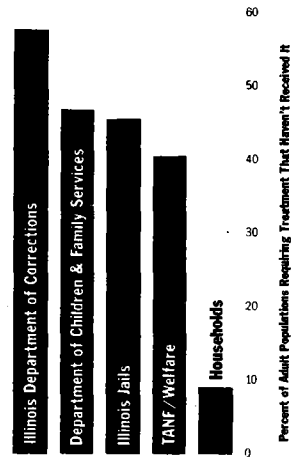
© 1998 TASC, Inc.

The Need for Treatment

Populations Supported by State Systems are Most in Need of Treatment

SOURCES
Treatment Needs Survey
Illinois Office of Alcoholism and Substance Abuse, 1996

An average of 50% of inmates in Illinois jails and prisons need substance abuse treatment. Additionally, more than 40% of DCFS and TANF clients need treatment.



© 1998 TASC, Inc.

A SUMMARY

of

ATHEY HALL

from the

EVALUATOR'S
SECOND YEAR REPORT (YEAR 02)

A RESIDENTIAL TREATMENT PROGRAM
FOR CHEMICALLY DEPENDENT WOMEN
AND THEIR CHILDREN

AN ILLINOIS DEMONSTRATION PROJECT

HAYMARKET CENTER OF McDERMOTT CENTER
AND
ILLINOIS STATE OFFICE OF ALCOHOL & SUBSTANCE ABUSE (OASA)

Center for Substance Abuse Treatment (CSAT)
Grant # 1 HD8 TI11120-02-000

Prepared By
Dr. Joyce A. Sween
November 1, 1997 ©

"Athey Hall has taught me a lot as far as parenting skills, being responsible, managing my life, and as far as the outside, being prepared for independent living. I feel more motivated now and very encouraged now that I understand the meaning of being responsible and I feel great about myself today, my self esteem is up more, and I'm determined to keep myself maintained."

(Athey Hall Client, Evaluator's Focus Group, Year 02)

INTRODUCTION

The Evaluator's Year 02 Report (September 30, 1997) provides an overview and assessment of the Athey Hall program's first two years. That Report contains 165 pages and 66 Tables, thus, the present Summary presents only a very brief overview of the evaluation results from the Report.

The Center for Substance Abuse Treatment (CSAT), which is funding the Athey Hall residential program for chemically dependent women and their children, considers the conducting of a comprehensive evaluation to be a critical component of the overall demonstration project. Both the national "cross-site" and the local evaluation are important aspects of the evaluation effort. The local evaluation, under the direction of Dr. Joyce A. Sween, also provides input to the national effort through the National Evaluation Data and Technical Assistance Center (NEDTAC). The local evaluation includes face-to-face survey interviews of clients and staff, focus groups, on-site observations at Athey Hall, and follow-up interviews of discharged clients.

The Athey Hall program is conducted on the sixth floor of Haymarket Center's six-story building. The area is neat and clean, airy and bright, and somewhat uplifting. Women clients are responsible for maintaining their individual rooms and the immediate area, including personal and children's laundry, vacuuming, dusting, etc. They are solely responsible for the care of their young children who reside there with them, and for attending the therapeutic group and counseling sessions, and participating in all other aspects of the program.

The uniqueness of the entire Athey Hall experience lies in the fact that it is so multi-focused and addresses numerous aspects of the women's physical, mental, and emotional problems. First and foremost, it provides a safe, stable, and structured environment for an extended period of time. Secondly, it does not separate mothers from their younger children, and provides the same stable and safe environment for the children as well. Once the clients develop a sense of relatively long-term (1 year) security, it is possible to address specifics such as drinking, drugs, education, parenting, and to start to help them develop the basis for creating a new life for their children and themselves.

SUMMARY OF ATHEY HALL'S TWO YEARS

- Over its first two years, the Athey Hall program has served 72 women and their accompanying 45 children. [See Evaluator's Report Year 02, Table 26, p.114.]

Athey Hall Client (Women and Children) Entry: Haymarket Center, April 10, 1996 - August 31, 1997.

CLIENT ENTRY:		ENTERED CLIENTS Total Women	Total Children
Year 01[1]			
April	(04/10/96 - 05/10/96)	26	16[2]
May	(05/11/96 - 06/10/96)	3	2[2]
June	(06/11/96 - 07/10/96)	5	7[2]
July	(07/11/96 - 08/10/96)	3	3[2]
August	(08/11/96 - 09/10/96)	6	5
Year 02[3]			
September	(09/11/96 - 10/10/96)	4	3[2]
October	(10/11/96 - 11/10/96)	2[3]	3[2, 3]
November	(11/11/96 - 12/10/96)	4	0
December	(12/11/96 - 01/10/97)	3	2
January	(01/11/97 - 02/10/97)	0	0
February	(02/11/97 - 03/10/97)	2	1
March	(03/11/97 - 04/10/97)	3	1
April	(04/11/97 - 05/10/97)	3[4]	3
May	(05/11/97 - 06/10/97)	3	0
June	(06/11/97 - 07/10/97)	1	0
July	(07/11/97 - 08/10/97)	3	0
August	(08/11/97 - 09/10/97)	2	0
TOTAL ENTRIES:			
	YEAR 01	**43**	**33**
	YEAR 02	**30**[5]	**13**[5]
2-YEAR TOTAL (4/96 - 8/97)		**73**[5]	**46**[5]
2-YEAR TOTAL (Unduplicated)		**72**	**45**

[1] In this Table, Year 01 includes the period after the Phase-In (April 10, 1996 - September 10, 1996).

[2] Includes children who were admitted to Athey Hall after their mother's entry date.

[3] Six (6) clients who entered as "sleep-overs" until a bed was available in their designated Haymarket Center program are not included in this Table (Year 02). However, one (1) client who had an extended stay (4 months) funded through another program's included in Year 02.

[4] Includes client originally funded by another program for a 3 month stay.

[5] Includes client/child re-entry, unduplicated client N Year 02 = 29, and children N Year 02 = 12.

- In addition, 163 non-resident children have benefited indirectly by their mother's participation. Overall, 208 children have been served or indirectly benefited. [See Evaluator's Report Year 02, Table 29, p.118.]

Children Served or Benefited by Athey Hall Program: Haymarket Center, April 10, 1996 - August 31, 1997.

	YEAR 01	YEAR 02	GRAND TOTAL (YEARS 01 & 02)
Total Young Children at Athey Hall	33	12[1]	45[1]
Total Young Children Not With Mother at Athey Hall	38	13	51
Total Older Children Not With Mother at Athey Hall	75	37	112
TOTAL CHILDREN SERVED ON ATHEY HALL			**45**
TOTAL OTHER NON-RESIDENT CHILDREN BENEFITED			**163**
TOTAL CHILDREN SERVED OR BENEFITED	**146**	**62**	**208**

[1]Excludes one (1) Year 01 client who re-entered Athey Hall in Year 02

[2]Excludes one (1) Year 01 child who re-entered Athey Hall in Year 02.

- The Athey Hall clients have been primarily African-American (86.1 percent), with a mean age of 32.2 years. Fifty-five percent did not complete high school. On average, they had 3.4 children. Crack/cocaine was the "drug of choice" for 81.9 percent. Four-fifths (81.6 percent) smoked cigarettes. [See Evaluator's Report Year 02, Tables 30, 31, p. 120 - 21; Table 33, p. 122.]

Characteristics of Athey Hall Clients: Haymarket Center, April 10, 1996 - August 31, 1997.

	Year 01(N=39)[1]	Year 02(N=33)[1]	2 YEAR TOTAL
AGE			
20 - 24 years of age	10.3%	9.0%	9.7%
25 - 29 years of age	15.4%	18.2%	16.7%
30 - 34 years of age	38.5%	51.6%	44.5%
35 - 39 years of age	25.6%	18.2%	22.2%
40+ years of age	10.3%	3.0%	6.1%
$\bar{X}$	32.8 years	31.4 years	32.2 years
Median Age	33.0 years	32.0 years	32.0 years
Range	20 - 47 years	22 - 42 years	20 - 47 years
ETHNICITY			
African-American	87.2%	84.8%	86.1%
Hispanic	5.2%	3.0%	4.2%
White	7.7%	12.1%	9.7%
MARITAL STATUS			
Single/ Separated/Divorced	97.4%	97.9%	97.6%
Married	02.6%	3.0%	2.8%
EDUCATION			
Less than high school diploma	56.4%	54.5%	55.5%
High School Graduate	20.5%	21.2%	20.8%
G.E.D.	05.1%	3.0%	4.1%
Some College or Other Training	17.9%	21.2%	19.4%
CHILDREN			
Client's Average/Median Number of Children			
$\bar{X}$ [mean] (SD)	3.6 (2.1)	3.1 (2.2)	3.4 (2.2)
median	4.0	3.0	3.0
range	0 - 9	1 - 8	0 - 9
Client's Total Number of Children[2]			
2 or less	28.2%	45.5%	36.1%
3	17.9%	27.3%	22.2%
4	28.2%	9.1%	19.4%
5	12.8%	12.1%	12.5%
6 or more	12.9%	6.0%	9.8%
SUBSTANCES USED			
Has used alcohol	84.6%	93.9%	88.7%
Has used crack/cocaine	82.0%	97.0%	88.9%
Has used heroin	41.0%	24.2%	33.3%
Has used marijuana	43.6%	88.8%	64.3%
Has used PCP	12.9%	9.1%	11.2%
Drug of Choice			
Crack/cocaine	76.9%	87.9%	81.9%
Tobacco Use			
Smokes cigarettes	77.0%	84.8%	81.6%

[1]Four clients who entered in September, 1996 are excluded from the Year 01 column and included in the Year 02 column. Year 02 excludes one (1) Year 01 client who re-entered.

[2]In Year 01, several of the older clients (35 years of age or older; N = 14) had had older children and/or children who had passed away.

- Since its inception, the Athey Hall program has conducted 657 group sessions for the women clients. These involved 9,231 client contacts. There were 19 different topical, educational, and therapeutic groups, which averaged 1.0 - 1.5 hours in length. [See Evaluator's Report Year 02, Table 4, p. 42.] The program has also provided, at a very minimum, one or more counseling sessions to all clients. Case management referrals were also made as required. [See Evaluator's Report Year 02, Table 5, p.44.]

Athey Hall Women's Group Sessions Provided: Haymarket Center, April 10, 1996 - August 15, 1997.

YEAR 01 (April 10, 1996 - August 31, 1996) Women's Component[1]	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Therapy	30	8.7	1.4	262
2. Shame and Guilt	17	7.2	1.0	122
3. Self-Esteem	11	8.5	1.2	93
4. Addictions	17	11.4	1.5	194
5. Women's Issues	13	15.8	1.0	212
6. Relationships	12	19.4	1.0	233
7. Health Education	06	14.0	1.0	84
8. Relapse Prevention	16	13.9	1.0	223
9. Budgeting	03	7.7	1.0	23
10. Independent Living	15	14.9	1.0	147
YEAR 02 (September 1, 1996 - August 15, 1997)				
Women's Component				
1. Therapy	92	13.3	1.3	1,222
2. Shame and Guilt	46	11.7	1.0	540
3. Self-Esteem	38	13.5	1.5	512
4. Drug Education	31	13.6	1.5	622
5. Women's Issues	25	20.4	1.0	511
6. Relationships	40	19.5	1.0	779
7. Health Education	28	13.6	1.0	382
8. Relapse Prevention	26	14.0	1.0	365
9. Decision Making Skills	27	12.6	1.0	340
10. (a) Independent Living	28	14.0	1.0	391
(b) Weekend Process/Wrap-Up	28	21.1	1.0	592
11. Lecture Groups (Treatment)				
A. Medical Issues	02	13.0	1.0	26
B. Nutrition	10	11.6	1.1	116
C. Gambling Addictions (started April)	04	8.7	1.0	35
D. Spirituality	37	16.3	1.0	606
E. Stress Management	27	13.9	1.1	376
F. Smoking Cessation	02	11.5	1.0	23
12. Lecture Groups (Education/Training)				
A. Computer Training (started May)	10	4.9	1.5	49
B. Legal Issues (started February)	09	9.2	1.0	108
13 Activity Groups				
A. Recreation	05	8.6	1.0	43
TOTALS	**657**			**9,231**

[1]Note Figures for Year 01 presented in this Table, and in subsequent Tables, differ slightly from those presented in the Year 01 Report due to year-end final calculations

- The Family Component has been newly developed during Year 02 with the resultant provision of family groups and activities. Non-resident family member participation has been encouraged. As a result, 92 visits by family members have been made to the unit for weekly Family Nites. In addition, there have been 273 visits by family members to the unit during regular visiting hours. Clients also attend Family Growth and Development groups (alone), and Family Lecture and Therapy groups (with family members). [See Evaluator's Report Year 02, Tables 11, 13; p. 73, 74.]

Athey Hall Family Group Sessions Provided: Haymarket Center, April 10, 1996 - August 15, 1997.

YEAR 01 (April 10 - August 31, 1996)

Family Component Groups	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
[No Family Groups Year 01]	--	--	--	--
YEAR 01 TOTAL	**0 0**			**0 0**

YEAR 02 (September 1, 1996 - August 15, 1997)

Family Component Groups	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Family Growth & Development (client only)	41	12.5	1.0	512
2. Family Lecture	29	11.9	1.0	345
3. Multi-Family (Therapy) Group	27	11.9	1.0	321 [clients][1] 92 [family]
4 Weekend Process/Wrap-Up*	(28)*	(21 1)*	(1 0)*	(592)*
YEAR 02 TOTAL	**97**			**1,178***

*These figures were included in Table 4 total and are excluded from total in this Table

[1]In addition 92 family members attended the Lectures and/or Multi-Family Groups, but are not included in the total.

❑ The Camp Algonquin visits are an element of what might best be called "adventure therapy." These consist of providing exposure for both mother and children and other family members[1] to environments which they might not otherwise ever experience. These "overnight" camp outings have been held approximately once per month for both years. Other experiences for residents have included trips to Marshall Field's for lunch, seeing a live play with real actors (not t.v.), and seeing Santa Claus and the Christmas lights in Chicago. In addition, between 10 - 41 family members have attended specific outings and events, such as the mother's luncheon by the Advisory Board on May 4. Even months after their participation, the mothers refer to these outings with great enthusiasm. [See Evaluator's Report Year 02, Tables 14, 19; pp. 76, 82.]

Camp Algonquin and Other Special Outings and Events: Athey Hall Women's Treatment Program, Haymarket Center, April 10, 1996 - July 31, 1997.*

Date	Event	Adults	Children
April 20 - 21, 1996[3]	Camp Algonquin	06	10
May 18 - 19, 1996	Camp Algonquin	05	07
June 29 - 30, 1996	Camp Algonquin	03	11
July 27 - 28, 1996	Camp Algonquin	04	09
August 1, 1996	Athey Hall Open House[1]	22	17
August 17 - 18, 1996	Camp Algonquin	04	09
September 14 - 15, 1996	Camp Algonquin	04	04
October 19 - 20, 1996	Camp Algonquin	05	05
November 9 - 10, 1996	Camp Algonquin	08	08
November 21, 1996	Singing Clown (on unit)	24	17
November 29, 1996	Circus Matinee	02	03
December 9, 1996	Christmas Lights Trolley Ride	23	13
December 10, 1996	Santa's Visit and Marshal Fields Walnut Room	15	10
December 20, 1996	Children's Party (with Santa Claus) by DASA Employees (on unit)[2]	24	17
December 27, 1996	Holiday Party (by Advisory Board, Athey Hall Unit)	39	17
January 30, 1997	"Toy Story" Disney on Ice (United Center)	10	10
February 14, 1997	"Rhythm: The Soul of Life." African American Ballet Company (Harold Washington Library)	07	04
February 24, 1997	"Use of African Drums" (Haymarket Center) (Black History Month Event)	15	00
March 1, 1997	Shriner's Circus	11	14
March 15 - 16, 1997	Camp Algonquin	03	06
March 22, 1997	Spring/Easter Children's Party and Egg Hunt (Athey Hall Unit)[3]	21	14
April 10, 1997	Betty Ford Visit (Athey Children presented flowers to Ms. Ford) (Haymarket Center)	10	08
April 12 - 13, 1997	Camp Algonquin	03	03
May 4, 1997	Sunday Pre-Mother's Day Luncheon[3] (by Advisory Board) (Haymarket Center)	56	06
May 5, 1997	Parenting Class Graduation (Haymarket Center)	05	00
May 17 - 18, 1997	Camp Algonquin	03	05
June 7 - 8, 1997	Camp Algonquin	03	05
July 12 - 13, 1997	Camp Algonquin	06	04
July 17, 1997	KiddieLand Amusement Park[2]	29	23
July 17, 1997	"Comfort Stew" [Play] (at the ETA Theater, 7552 S. Chicago Avenue)	05	00
August 16 - 17, 1997	Camp Algonquin	06	01

[1]Clients gave a presentation (see Year 01 Report). Guests included 30 persons, representing 25 outside organizations
[2]Children were given books and teddy bears. Monsignor McDermott, Senator Margaret Smith, and DASA employees were present.
*Also included are visiting children, family members/friends, as applicable.

- In Year 02, there has also been a major increase in the number of peer/self-help sessions, including the addition of the new "Women-to-Women" group into this component of the program. There were 180 Self-Help group sessions, representing 2,142 client contacts in Year 02. [See Evaluator's Report Year 02, Table 17, p. 80.]

Athey Hall Self-Help Group Sessions Provided: Haymarket Center, April 10, 1996 - August 15, 1997.

YEAR 01 (April 10 - August 31, 1996)

Self-Help Component Groups	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Self-Help	16	20 2	1 4	323
2. Twelve Step Group*	—	—	—	—
YEAR 01 TOTAL	**16**			**323**

YEAR 02 (September 1, 1996 - August 15, 1997)

Self-Help Component Groups	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Self-Help	109	11.7	1.1	1,275
2. Twelve Step Group	47	12.2	1.2	575
3. Women-to-Women	24	12 2	1 1	292
YEAR 02 TOTAL	**180**			**2,142**

*Athey Hall clients attended Step-Groups in Year 01, but client attendance information was not available. The Woman-to-Woman group was not provided during Year 01

- The Children's treatment has consisted of 359 developmental play groups with the Child Development Specialist staff. Children also participated in various outings and individual one-on-one sessions were provided for each child and mother. [See Evaluator's Report Year 02, Table 7, p. 60.]

Athey Hall Children's Group Sessions Provided: Haymarket Center, April 10, 1996 - August 15, 1997.

YEAR 01 (April 10 - August 31, 1996)

Children's Component	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Play Group (Structured)	82	6.3	1.3	517 (child)
YEAR 01 TOTAL	**82**			**517**

YEAR 02 (September 1, 1996 - August 15, 1997)

Children's Component	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Play Group (Structured)	277	5.6	1.2	1,538
YEAR 02 TOTAL	**277**			**1,538**

- Parenting was enhanced through 62 educational sessions and 90 interactive mother/child "Sunshine Time" groups. In Year 02, women without young children on the unit attended an alternative 12-Step Book Study group (11 sessions). [Refer to Evaluator's Report Year 02, Table 9, p. 67.]

Athey Hall Parenting Group Sessions Provided: Haymarket Center, April 10, 1996 - August 15, 1997.

YEAR 01 (April 10 - August 31, 1996)

Parenting Component	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Parenting	18	11.7	1.2	211
2. Sunshine Time	29	6.6 (mothers) 9.1 (children)	1.0	455 (190 mothers) (265 children)
YEAR 01 TOTAL	**47**			**666**

YEAR 02 (September 1, 1996 - August 15, 1997)

Parenting Component	N Sessions	Average Session Size (clients)	Average Session Length (hours)	N Client/Session Contacts
1. Parenting	44	9.3	1.4	408
2. Sunshine Time	61	6.7 (mothers) 8.5 (children)	1.0	931 (410 mothers) (521 children)
3. Twelve Step Book Study	11	8.0	1.0	88
YEAR 02 TOTAL	**116**			**1,427**

- The Athey Hall program has discharged 48 clients, with 64.6 percent completing the program. [See Evaluator's Report Year 02, Tables 44, 45; pp. 135, 136.]

Athey Hall Client Discharges by Discharge Date: Haymarket Center, April 10, 1996 - August 31, 1997.

DISCHARGE TIME PERIOD		DISCHARGED CLIENTS: Completed Athey Hall/ Discharge to Community	Medical Discharge/ Discharge to Other Treatment	Discharged Against Staff Advise (ASA)	Discharged for Patient Non-Compliance (PNC)	TOTAL Discharges
YEAR 01						
April	(04/10/96 - 05/10/96)	1	0	0	0	1
May	(05/11/96 - 06/10/96)	2	0	1	1	4
June	(06/11/96 - 07/10/96)	4	0	0	1	5
July	(07/11/96 - 08/10/96)	2	0	1	0	3
August	(08/11/96 - 09/10/96)	8	0	0	0	8
YEAR 02						
September	(09/11/96 - 10/10/96)	1	0	1	1	3
October	(10/11/96 - 11/10/96)	1	0	1	1	3
November	(11/11/96 - 12/10/96)	1	0	0	0	1
December	(12/11/96 - 01/10/97)	0	0	2	0	2
January	(01/11/97 - 02/10/97)	0	0	2	0	2
February	(02/11/97 - 03/10/97)	0	0	2	1	3
March	(03/11/97 - 04/10/97)	0	0	1	0	1
April	(04/11/97 - 05/10/97)	3	0	0	0	3
May	(05/11/97 - 06/10/97)	2	0	1	0	3
June	(06/11/97 - 07/10/97)	2	0	0	0	2
July	(07/11/97 08/10/97)	3	0	0	0	3
August	(08/11/97 08/31/97)	1	0	0	0	1
TOTAL CLIENTS DISCHARGED (Unduplicated)*						
	YEAR 01	17	0	2	2	21
	YEAR 02	14	0	10	3	27
2-YEAR TOTAL		**31**	**0**	**12**	**5**	**48**
Percent of Discharged Total		**64.6%**	**0.0%**	**25.0%**	**10.4%**	**100.0%**

- Attempts to follow-up discharged clients required a very extensive effort by the Evaluation team, including 787 phone calls. Overall to-date, 68.2 percent of the discharged Athey Hall clients have been reached and interviewed. The preliminary post-discharge results show approximately one-half of the discharged clients to be living independently and approximately two-thirds to be attending self-help groups in the community. Approximately sixty percent were working, and about one-third were pursuing a G.E.D. or other training. Less than one-half were receiving welfare payments or food stamps. [See Evaluator's Report Year 02, Tables 48 - 51, pp. 144 - 145.]

Statuses at Time of Interview of Athey Hall Discharged Clients: Haymarket Center, April 10, 1996 - July 31, 1997.

STATUS AT INTERVIEW	Client Interviewed at Least Once*							
	1 Month		3 Months		6 Months		1 Year	
	N	%	N	%	N	%	N	%
Work Status								
Full-Time	12	50.0	9	42.9	13	61.9	3	60.0
Part-Time	3	12.5	3	14.3	4	18.6	0	0.0
Unemployed	9	37.5	9	42.8	4	19.0	2	40.0
Education (Since Discharge)								
G E D Enrolled	3	12.5	2	9.5	7	33.3	0	0.0
Other Enrolled Education/Job Training	7	29.1	4	19.0	3	14.2	0	0.0
Completed G.E.D.	0	0.0	1	4.8	0	4.8	0	0.0
Completed Other Education/Job Training	2	8.3	2	9.5	1	4.8	0	0.0
Major Income Source - Public Aid	6	25.0	9	42.9	7	33.3	2	40.0
Receives Food Stamps	13	54.2	6	28.6	10	47.6	2	40.0
Receives Medicaid	9	37.5	3	14.3	6	28.6	1	20.0
Housing								
Apartment/House by self	11	45.8	10	47.6	12	57.1	4	80.0
Public Housing/Shared Housing	4	16.7	6	28.6	6	28.6	0	0.0
Recovery Home/Group Home/Shelter	9	37.5	4	19.0	3	14.3	0	0.0
Unknown	0	0.0	1	4.8	0	0.0	1	20.0
Self-Help (12-Step) Group Attendance	22	91.7	14	66.7	14	66.7	4	80.0
DCFS Involvement	0	0.0	1	4.8	2	9.6	0	0.0
Criminal Justice System Involvement (Detained or Arrested)	8	33.3	9	42.8	8	38.1	0	0.0
ATI Involvement	2	8.3	2	9.5	2	9.5	0	0.0
TOTAL INTERVIEWS	24	100%	21	100%	21	100%	5	100%

*By July 31, 1997 - NOTE: Clients may have multiple interviews. (For clients discharged by June 30, 1997, the 30 day interview date would be by July 30 1997.)

- Of the discharged clients, 11.4 percent self-reported drug or alcohol use since their discharge. An additional 9.1 percent were reported "using" by friends and/or relatives. This represents the *minimum* recidivism rate of 20.5 percent. However, if we assumed "all" unknown status clients (22.7 percent) had recidivised, 43.2 percent would be the *maximum* drug/alcohol recidivism proportion. The actual recidivism rate would, thus, be between 20.5 - 43.2 percent. [See Evaluator's Report Year 02, Table 54, p. 148.]

Estimated *Maximum/Minimum* Drug/Alcohol Recidivism of Athey Hall Discharged Clients: Haymarket Center, April, 1996 - June, 1997 (interviewed by July 31, 1997).

	N	Percent
Client Interviewed		
Reports No Recidivism[1]	25	56.8%
Reports Alcohol Use[2]	02	04.5%
Reports Substance Use[3]	01	02.3%
Reports Both[2]	01	02.3%
Reported use in Post 7/31/97 interview[2]	01	02.3%
Client Not Interviewed		
Reported Recidivism by Friend/Relative[3]	04	09.1%
Recidivism Unknown[4]	10	22.7%
TOTAL DISCHARGED*:	44	100.0%
ESTIMATED RECIDIVISM		
Maximum (all "Unknown" considered recidivised)	19	43.2%
Minimum (all "Unknown" considered NOT recidivised)	9	20.5%

*By June 30 1997
[1]Client reports never using alcohol or other substances since discharge
[2]Client reports occasional use.
[3]Friend/relative reports discharged client "on the streets" or "using."
[4]No post-discharge contact with client or with client's relatives/friends.

* * * *

* * * *

"Butterfly"*

Today, i feel like a butterfly
flying high on my dreams
And flying free.
Flying high and flying low,
Today i feel
like a butterfly.
Beauty is mine.
Flying free and full of color
This is how i feel today
About my self-esteem.
Like a
new butterfly coming out of
its cocoon full of life.
Bright and beautiful, flying
high and flying free

"My Poem"*

Caterpillar creeping real smooth.
Take my time to make my move.

Go in carrying, hiding myself in my shell.
Wrapped in my own life. Keeping to myself.

Now, I'm spreading my wings.
Exploring on my journey.

* * * *

*Poems by Athey Hall clients.

Addiction (1998) 93(7), 979–990

REVIEW

Researching the spiritual dimensions of alcohol and other drug problems

WILLIAM R. MILLER

Department of Psychology and Center on Alcoholism, Substance Abuse, and Addictions (CASAA), The University of New Mexico Albuquerque, New Mexico, USA

Abstract

Although religions have been far from silent on the use of psychoactive drugs, and spirituality has long been emphasized as an important factor in recovery from addiction, surprisingly little research has explored the relationships between these two phenomena. Current findings indicate that spiritual/religious involvement may be an important protective factor against alcohol/drug abuse. Individuals currently suffering from these problems are found to have a low level of religious involvement, and spiritual (re)engagement appears to be correlated with recovery. Reasons are explored for the lack of studies testing spiritual hypotheses, and promising avenues for future research are discussed. Comprehensive addictions research should include not only biomedical, psychological and socio-cultural factors but spiritual aspects of the individual as well.

Introduction

The history of alcohol and other drug use is intertwined with spirituality and religion. The use of specific psychoactive agents is proscribed in certain religious traditions, and prescribed in others. The influential Twelve-Step programs, arising from Alcoholics Anonymous and its protestant roots (Kurtz, 1979), have always understood both the etiology of and recovery from addiction in fundamentally spiritual terms, yet surprisingly little empirical research has focused on this aspect of addiction and its treatment. This paper considers how spiritual dimensions are pertinent to and proper subjects for addiction research. Although I have sought to take a broader perspective, I must acknowledge the Christian culture that has shaped my own understanding, and within which much of the cited research has been conducted.

Spirituality versus religion

Science begins with definition and observation. The concept of spirit is often defined in contrast to matter, and spirituality in contrast with materialism. To speak of the spiritual is to refer to that which is transcendent or transpersonal. Descriptively, this might be captured in the general assertion that "we *have* bodies, but we are not our bodies". Whether or not a scientist personally embraces this view, it is one that has characterized most of humankind throughout recorded history, and as an attribute of humanity it is a proper subject for scientific investigation (James, 1902).

An important distinction, passionately so in some circles, is that between spirituality and religion. The following brief points of differentiation may be helpful.

(1) Spirituality is typically understood at the

Correspondence: William R. Miller, PhD, Department of Psychology, University of New Mexico, Albuquerque, NM 87131-1161, USA.

Submitted 10th July 1995; initial review completed 11th December 1995; final version accepted 6th January 1998.

0965–2140/98/070979–12 $9.50 © Society for the Study of Addiction to Alcohol and Other Drugs

Carfax Publishing Limited

level of the individual. As with personality, there are nomothetic dimensions that can be meaningfully compared across people, but spirituality is fundamentally an idiographic aspect of the person. Religion, in contrast, is a social phenomenon, an organized structure with many purposes, one of which historically has been the development of spirituality in its members. Individuals can, of course, be characterized in terms of their religiosity, the extent to which they are engaged in religious belief and practice.

(2) Spirituality, as we shall see, is very difficult to delimit. By its focus on the transcendent, it defies customary conceptual boundaries. Religion, in contrast, is *defined* by its boundaries—by particular beliefs, practices, forms of governance and rituals (Kurtz & Ketcham, 1992). For this reason, religion has been the easier of the two to define and measure in operational terms.

(3) It is conceivable that at least certain forms of religion interfere with or distort one's spirituality. This has, in fact, been a warning in some spiritual teachings. Spirituality may be obscured, for example, when ritual, rules and practice become important in their own right and their purpose is forgotten. Thought of in this way, the relationship between spiritual and religious variables is a potential subject for empirical investigation.

A scientific definition of spirituality must be one that does not rely upon particular religious contexts, that is accessible and observable regardless of one's personal beliefs, and that can thereby be used to characterize all people. Dichotomies (such as whether a person is "spiritual" or not), classification systems (e.g. spiritual, religious, both, or neither) and single continuous dimensions (e.g. more versus less spiritual), while possible, all fall short in capturing the complexity of this side of human nature.

Rather, spirituality is multi-dimensional. One useful approach is to think of it as a latent construct, such as health, happiness or personality (Miller & Thoresen, 1998; Larson, 1998). Its dimensions would include at least:

- overt *behavior*, such as religious and spiritual practices;
- *belief*, as regards a deity, interrelatedness of living beings, soul or spirit, and life beyond material existence etc.; and
- *experience*, such as mystical and convictional experiences, serenity and oneness.

Although not widely known in scientific circles, there is a large and well-developed psychometric literature on the measurement of spiritual and religious constructs (Spilka, Hood & Gorsuch, 1985; Richards & Bergin, 1997). If the measurement of spiritual constructs has been rare in addiction research, it is not for lack of reliable instrumentation.

Religion and addictive behaviors

A Judeo–Christian perspective

Although most modern drugs of abuse were unknown at the time that Judeo–Christian scriptures were written, alcohol is the subject of some clear biblical injunctions. There is no blanket condemnation of alcohol use in Jewish and Christian scripture; on the contrary, the drinking of wine is assumed to be part of ordinary life and is even commended. Central sacramental observances in both Judaism and Christianity involve the use of wine. There is clear and consistent biblical denunciation, however, of *drunkenness*—the use of alcohol in a manner that inflicts impairment and harm. It is this excessive use of alcohol, what we would today call "abuse", that is denounced as sinful (Advisory Council on Church and Society, 1986). If one extends these teachings to the use of psychoactive drugs more generally, it is at the point of inflicting harm or risk of harm on oneself or others that drug use crosses over into the realm of sinfulness (Miller, 1995).

If sin is that which separates humanity from God, these are biblical expressions of the same idea underlying the ancient epithet *spiritus contra spiritum*, cited by Carl Jung in a letter to Bill Wilson, the co-founder of Alcoholics Anonymous (Jung, 1961/1975). The fundamental idea is that the abuse of alcohol, which interestingly came to be called "spirits", is in some manner incompatible with spirituality. One drives out the other. This understanding is fundamental within the core writings of Alcoholics Anonymous (AA) (AA, 1939; Kurtz, 1979; Kurtz & Ketcham, 1992). The essence of AA's program is not the disease model with which it has so often been confused, but the understanding that an alcoholic's best, if not only, hope for sobriety is through recognizing, appealing to, accepting

help from and directing his or her life toward a transcendent higher power, referred to as "God" in AA's Twelve Steps (Miller & Kurtz, 1994). These steps are worked not just once as an act of salvation, but rather as an ongoing lifelong program for living. Sobriety is similarly understood in a spiritual context, as involving far more than being abstinent. It is taken for granted within AA that one can be dry but not sober, the latter having to do with a spiritual maturity that involves acceptance, humility and serenity. It is, in AA's understanding, spirituality that finally and reliably drives out the possessive spirits of addiction. Although AA meetings vary in many ways, one of the more reliable consistencies across groups is the presence of this emphasis on spirituality as the road to new life (Montgomery, Miller & Tonigan, 1993).

Looked at from the other direction, addiction has been suggested as a useful metaphor for understanding sin more generally (May, 1991). Current diagnostic concepts of addiction, which focus on dependence syndrome (Edwards & Gross, 1976; American Psychiatric Association, 1994), describe a phenomenon that slowly takes over a person's life, displacing all else. The addict's time, resources and energies are gradually focused more and more on acquiring, using and recovering from drugs. Prior interests and activities are progressively shunned as drug use becomes the central and dominant object of attention. Forsaking all else, seemingly oblivious to the detrimental consequences, the addict walks a narrow path in search of euphoria and oblivion, and is increasingly lost in drugs' embrace. In sum, drugs come to occupy the position of a higher power. In this sense, addiction is one of the clearest enduring models of idolatry—giving to something material that which is the rightful place of God. This is the other meaning of *spiritus contra spiritum:* spirits (or, more generally, drugs of abuse) drive out spirituality.

Other religious perspectives

Although research and writings on addiction have often arisen from a Judeo–Christian context and its ambivalence toward psychoactive substances (Mäkelä, 1975), there is a great variety of perspectives on drug use among world religions. There is a large sociological and anthropological literature on the role of alcohol and other drugs in religious life. Few religions are neutral on the subject. Some, such as Islam, strictly proscribe any ingestion of alcohol and certain other drugs. On the other hand, native American, Polynesian, African and other indigenous religions have often used hallucinogenic and other psychoactive substances (e.g. peyote, khat, alcohol, tobacco and hashish) as vehicles in the quest for spiritual transcendence, and some religious are characterized as based on or inspired by drug use (Lyttle, 1988). There is, in short, a diversity of religious understanding as to whether the altered states induced by psychoactive drugs invoke, threaten, or are irrelevant to personal spirituality. What is of interest is that most religions infer *some* direct link between psychoactive substances and spirituality.

Spirituality and addiction research

Given these long-standing connections between religion and substance use, and the important role of religious and spiritual perspectives in shaping at least western understandings of addiction, it is odd indeed that so little research has been devoted to this interface (Miller, 1990). At least four broad areas of investigation suggest themselves readily. Research has explored, and could further clarify, the role of spiritual/religious variables: (1) as risk or protective factors for substance use and problems; (2) as elements of the course of addiction disorders; (3) as dependent variables influenced by alcohol/drug use; and (4) as components of the recovery process. These correspond roughly to the use of spiritual constructs and measures in research as predictor, dependent, covariate and independent variables. Clear hypotheses can be derived and tested in these areas, assuming the reliable measurement of spiritual variables.

Spiritual protective and risk factors

There is strong evidence that spiritual/religious involvement is generally associated with decreased risk of alcohol/drug use, problems and dependence. Data pertinent to this question have often been gathered incidentally as a part of larger survey research. Reviews of this literature have concluded that religiously involved individuals are consistently less likely to use alcohol and other drugs, and when they do so are less likely to engage in heavy use and suffer its adverse

consequences (Gorsuch & Butler, 1976; Gartner, Larson & Allen, 1991; Gorsuch, 1995; Larson, 1998). This effect persists even when measures of spiritual/religious involvement have been relatively crude (e.g. denominational affiliation). "Whenever religion is included in an analysis, it predicts those who have *not* used an illicit drug regardless of whether the research is conducted prospectively or retrospectively and regardless of whether the religious variable is defined in terms of membership, active participation, religious upbringing, or the meaningfulness of religion as viewed by the person" (Gorsuch & Butler, 1976, p. 127).

Interestingly, there are substantive differences among religious denominations in the risk of alcohol problems (Mäkelä, 1975; Koenig *et al.*, 1994). Those of Jewish faith are typically found to have relatively low rates of alcohol problems and dependence, despite low rates of total abstention. Differences among US denominations are sharpened when one considers the rate of problems and dependence among *current drinkers*. Given that one is a drinker, the risk of problems and dependence is highest among conservative Protestant denominations, where abstinence is the norm. Nevertheless, even in this highest-risk group, the risk for drinkers is only 40% of that for drinkers with no religious affiliation (Hilton, 1991).

What are the actual protective mechanisms involved in these relationships? Measures of religious involvement have often been coarse, providing little information about specific religious beliefs, practices and contexts. Is the principled avoidance of drugs a key factor? Is it the presence of social support for abstinence or moderation? Does religious involvement engage the person in time-occupying activities that compete with and are incompatible with drug use? Might a life free of drug involvement be part of a larger complex of prosocial values that are promoted by religious affiliation? The correlation between spiritual/religious involvement and lower risk is one of the more consistent (although seldom taught) findings of the addiction field, but causal inferences cannot be drawn from current findings. Investigation of the reasons for this relationship should be a high priority among topics for research in this area (Larson, 1998).

It follows that among religious variables are also some risk factors, associated with *increased* risk of future substance use and problems. From the above evidence, a lack of religious involvement is such a predictive factor. It may also be that certain aspects of spirituality or religion are linked to risk. Gorsuch (1995) has suggested that one's concept of God (a well-studied and measurable phenomenon) may be linked to the likelihood of substance abuse. Those with a more wrathful, punitive conception of God may be at higher risk for developing problems with alcohol and other drugs. Individuals affiliated with religious groups that show a higher incidence of substance use and abuse would themselves be expected to be at higher risk. Again, the direction of causality is unclear. Modeling may shape attitudes and behaviors but, as in assortative mating, adults also tend to affiliate with groups that more resemble their own behavior patterns.

Spirituality in the course of addiction

If spiritual/religious involvement generally serves as a protective factor against substance abuse, and if spirituality and the abuse of spirits are somehow incompatible then it follows logically that individuals who are currently caught up in addiction would be expected to be less spiritually active or religiously involved. This topic has seldom been investigated, perhaps because of remaining echoes of a moralistic model that blames alcoholics or addicts for being morally deficient. It is possible, however, to separate a spiritual model of addiction from moralistic views (Miller & Kurtz, 1994; Miller & Hester, 1995). Spiritual variables can be understood as potential determinants (or at least correlates) of the course and severity of drug problems, much like more commonly discussed etiologic factors such as physiological, genetic, psychological, family and socio-cultural influences. People with alcohol and other drug problems are commonly found to be also impaired on cognitive, psychological, medical and social dimensions. How do they fare on measures of spiritual dimensions?

In general, alcohol/drug problems are associated with a current lack of religious affiliation and involvement (Walters, 1957; Larson & Wilson, 1980; Hilton, 1991). Women who are partners of alcoholic men also report themselves to be substantially less religious in both attitude and behavior (Ichiyama *et al.*, 1995).

Religious involvement, however, is only one dimension of spirituality. It would be of interest

to study more general spiritual aspects of the course of addictions. It is possible, for example, that a lack of religious involvement is irrelevant to risk or course given other forms of active spirituality. The practice of transcendental meditation is associated with lower risk, and may be beneficial in recovery (Aron & Aron, 1980). Lower risk of alcohol use disorders has been associated with private practices of prayer and scripture reading (Koenig *et al.*, 1994). A more generic spiritual dimension that has been researched in the addiction field is the sense of meaning in life, particularly using the Purpose in Life scale (PIL; Crumbaugh & Maholick, 1964). More than a dozen studies have found that alcohol/drug abuse is associated with a lack of sense of meaning in life, relative to normal samples (Crumbaugh & Maholick, 1969; Black, 1991).

The longitudinal protective relationship between religious involvement and substance abuse may or may not hold once problems are established. Within a group already impaired by alcohol, there may be no strong relationship between religious involvement and problem severity (Mookherjee, 1986). We recently examined this relationship in a large clinical sample (Project MATCH Research Group, 1997), comparing two summary scores from the Religious Background and Behavior scale (RBB; Connors, Tonigan & Miller, 1996) with 16 measures of severity of drug use, alcohol consumption, problems and dependence. We found the RBB scale total to be normally distributed within this sample, and to have excellent test-retest reliability. Although the correlations generally reflected a modest association between higher religious/spiritual involvement and better outcomes, none exceeded $r = 0.15$. One obvious explanation for why relationships would be found in a general population but not within clinical samples is the restricted range of the latter, similar to the difficulty of predicting graduate school grades from aptitude scores.

In any event, spiritual variables can be included in studies of the course of addictions. Indeed, the US Joint Commission on the Accreditation of Healthcare Organizations has recommended and required the routine assessment of spirituality in the delivery of health care. Spiritual aspects of health may be helpful in understanding, and ultimately in facilitating, the process of recovery.

Alcohol/drug use and spirituality

Because the observed relationship between spirituality and addictive behaviours is correlational, causality may flow in either, both or neither direction. The excessive use of certain psychoactive drugs may exert detrimental effects on spirituality, as it does on physical and psychological health. It must be remembered here, too, that certain drugs have sacred uses, and are used within some religions to facilitate deeper spirituality.

Relatively little research has explored psychological factors or interventions that facilitate spiritual wellbeing (Ellison & Smith, 1991; Martin, 1998). Study designs (such as cross-lagged correlational analyses in longitudinal research) are available for untangling whether prediction is stronger from spiritual factors (at Time 1) to alcohol/drug variables (at Time 2), of from alcohol/drug factors to subsequent spiritual variables. The dictum *spiritus contra spiritum* suggests that both paths may be important.

Spiritual correlates and mechanisms of recovery

If religious involvement is a protective factor, and if current substance abuse is associated with a lack of spiritual/religious involvement, do spiritually focused interventions promote recovery from alcohol/drug problems? Many have maintained that a spiritual focus represents an important route to recovery (Alcoholics Anonymous, 1939; Clinebell, 1956, 1963). Although some have emphasized "getting religion" as a cure, spiritual approaches have usually focused on broader issues of meaning and character.

There is limited empirical evidence at present for a predictive relationship of spirituality to recovery. Research could clarify whether particular spiritual activities are particularly predictive of better outcomes. Certainly a promising place to study spirituality in the recovery process is within Twelve-Step fellowships such as AA (McCrady & Miller, 1991). Corrington (1989), for example, found that among AA members spirituality, as measured by Whitfield's (1984) Spiritual Self-Assessment Scale, was predictive of life satisfaction. This relationship was independent of the length of involvement in AA. AA attendance is often found to be modestly predictive of better treatment outcomes (Emrick *et al.*, 1993). In one study (Montgomery, Miller & Tonigan, 1995),

we found that drinking outcomes were unrelated to the extent to which clients *attended* AA after treatment. When we measured the extent to which clients had become *involved* in AA, however, a significant relationship emerged. Those who were more involved in working program steps and in AA-recommended activities were more likely to be abstinent.

To date, only a few systematic evaluations have focused on the application of specific spiritually derived strategies as an aid to recovery. Meditation of various kinds has been found to be helpful in health promotion (Martin & Carlson, 1988), and has been applied in the prevention and treatment of addictive behaviors (e.g. Marlatt & Marques, 1977; Aron & Aron, 1980). The only controlled trial to date, however, found no specific effect of meditation on alcohol consumption of heavy drinkers (Murphy, Pagano & Marlatt, 1986).

Building on an already large literature (Finney & Maloney, 1985; Dossey, 1993), Walker and his colleagues (1997) conducted the first double-blind randomized trial of intercessory prayer for alcoholics in treatment. No beneficial effect was observed but an unexpected finding, if replicable, bears better understanding. Clients who reported, before treatment, that they were aware of someone already praying for them, also showed higher levels of continued drinking at 6-month follow-up. The use of prayer by clients themselves, however, was associated with better outcomes.

Project MATCH (1993) is certainly the largest randomized trial of a spiritually based treatment. Its Twelve-Step facilitation therapy (TSF; Nowinski, Baker & Carroll, 1992) was compared with cognitive–behavioral skill training and with motivational enhancement therapy. The TSF treatment was specifically designed to engage clients actively in AA and to help them work through the first few steps of AA's spiritual program. Clients assigned to TSF fared at least as well as those in the other two treatment conditions, and on measures of complete abstinence showed significantly better outcomes (Project MATCH Research Group, 1997). Across all treatment groups, both AA involvement and religious/spiritual involvement were found to be modestly and positively related to outcomes.

Religious practices and recovery

As there can be religious overtones to how one understands the nature of drug use and problems, religious practices have also been invoked in the search for healing of addictions. The word "healing" is used here as a broader term than "treatment", which connotes the intentional application of technological procedures. Healing connotes the broader context of recovery, which extends well beyond formal treatment.

If there are spiritual aspects to the problem, then spirituality may also hold part of the solution (AA, 1939). Indeed, spiritually and religiously based practices have been used to address alcohol and other drug problems. There is a literature on the practice of transcendental meditation in the prevention and treatment of addictive behaviors (Aron & Aron, 1980; Marlatt & Gordon, 1998). In the United States, explicitly Christian recovery programs have been offered by groups including the Salvation Army and Teen Challenge, among others. In Native American religion, peyote has been used to treat alcohol dependence (Albaugh & Anderson, 1974). The Twelve Steps of AA explicitly include gaining awareness of a "higher power" beyond oneself, turning over one's will to and asking for help from the higher power, confessing and making amends for wrongs, practising prayer and meditation and seeking to conform oneself to the will of the higher power.

To what extent are changes in spiritual variables important markers or components of recovery? From some perspectives, spiritual development is a *sine qua non* of stable sobriety (AA, 1939). Brown & Peterson (1990b) found marked shifts in clients' reported values before versus after alcoholism treatment, and speculated that a reprioritizing process may be part of stable sobriety. Just as spiritual/religious variables appear to be protective factors against the development of substance use disorders, they may also mark or facilitate the process of recovery (Muffler, Langrod & Larson, 1992). Well-designed research has only begun to explore this domain.

Another phenomenon worthy of exploration is the kind of sudden and dramatic transformation that began Bill Wilson's own sobriety (Kurtz, 1979). Retrospective histories of recovery not infrequently include critical incidents that may be characterized as or likened to spiritual conversion experiences (e.g. Tuchfeld, 1981; Edwards, Oppenheimer & Taylor, 1992). Barlow, Abel &

Blanchard (1977) documented in detail the case of a transsexual male who underwent comprehensive and enduring gender identity change following two sessions of prayer, changes that normally require a year or more of intensive treatment if they occur at all. We have termed these "quantum change" experiences, in which a personality is permanently turned upside down, usually for the better, in a matter of minutes or hours. Such sudden and major turning points are well worth understanding, and may hold some keys to spiritual processes that can operate in life transformation (Miller & C'de Baca, 1994). I suspect that the underlying processes are linked in some way to the consistent behavior changes that are observed following brief motivation-focused treatments (Miller & Rollnick, 1991; Bien, Miller & Tonigan, 1993).

Barriers to research on spirituality and addiction

Given the long history and common association of spirituality and addiction, why has research on this relationship been so sparse? In studies of treatment, spiritual variables are seldom even measured. Those who have written most prolifically about spiritual aspects of addiction (e.g. Clinebell, 1956; Kurtz, 1979; Brown, Peterson & Cunningham, 1988; May 1991) have rarely submitted their assertions to scientific verification. Most productive treatment researchers, who commit their lives to scientific investigation of therapeutic processes and outcomes, seem rarely to have considered spirituality as a dimension worthy of investigation. The growing interdisciplinary biopsychosocial perspective spans physical, psychological, interpersonal, financial, legal, sexual, emotional, social, vocational and, more recently, quality-of-life aspects of adjustment, but virtually no consideration has been given to spirituality. There are no spiritual adjustment scales on the instruments designed to be broad evaluations of treatment outcome, such as the Addiction Severity Index (McLellan *et al.*, 1990) the Comprehensive Drinker Profile (Miller & Marlatt, 1984) or the Alcohol Use Inventory (Horn, Wanberg & Foster, 1987).

What have been the barriers to research on spirituality and addictions? Relative to the general population, religious beliefs and values are dramatically under-represented among US mental health professionals in general and among psychologists in particular, who conduct much of the treatment outcome research on alcohol/drug problems (Bergin, 1980; Bergin & Jensen, 1994; Shafranske, 1996). The typical training of researchers such as psychologists is at best devoid of consideration of spiritual issues (Clement, 1978), and most scientists consequently lack the knowledge base and tools needed to study spiritual variables even if they had the urge. Meanwhile, those in the addictions field who have been most expert and interested in spirituality appear to have lacked the training, inclination or resources to pursue empirical research on their passion. There are, I believe, some important steps that could be taken to facilitate the design and conduct of such research.

Overcoming barriers

First, I would argue that we do *not* need any more specialty journals in this area. There are already many addiction journals (Arciniega & Miller, 1997) and a number of well-established journals publishing research at the interface of spirituality and mental health, including the *Journal of Ministry in Addiction and Recovery*. Continuing to publish research in specialized spiritually orientated publications with limited readership is preaching to the choir. The choir is a vocal but small part of any congregation. I would urge instead that well-designed research linking spirituality and addictions (or mental health issues more generally) should be peer-reviewed and published in mainstream scientific journals.

Secondly, I believe that it is important for scientists interested in this area to communicate and cooperate with one another. An excellent headstart in this direction occurred with the convening of several expert panels of scientists to develop consensus statements regarding past and future research on spirituality and health (Miller & Bennett, 1997; Larson, 1998). There are also opportunities through professional organizations, some of which have special divisions or interest groups focused on spiritual/religious issues (e.g. Division 36 of the American Psychological Association, and the Association for the Advancement of Behavior Therapy special interest group on "Spiritual and Religious Issues in Behavior Change"). Such groups can work together creatively to conceive and design high-quality re-

search on the role of spirituality in treatment and healing.

We also need to address the fact that the diversity training of psychological and medical researchers typically includes no serious consideration of spiritual and religious issues, despite the presence of a large volume of studies showing positive relationships between religious involvement and health (Bergin, 1983; Larson *et al.*, 1986, 1992; Levin & Vanderpool, 1987; Levin, 1994; Gorsuch, 1995; Larson, 1998). If we do not train future scientists to think about spiritual issues—or worse, if we teach them *not* to think about such matters because they are "unscientific"—we will perpetuate the current paucity of quality research on spiritual issues in recovery. Psychologists are the presumed experts on measurement of human behavior, but most have no idea how to measure spiritual constructs. Excellent training resources are beginning to appear that can be incorporated into professional training (e.g. Matthews, Larson & Barry, 1993; Shafranske, 1996; Richards & Bergin, 1997; Pargament, 1998).

It would be more generally useful to come to some consensus about the most important dimensions to measure when one wants to assess spirituality within clinical research. Some scales that purport to measure spirituality have many diverse elements. Whitfield's (1984) spirituality scale, for example, included items such as "I am honest with myself", "I feel sexually fulfilled" and "I exercise regularly". It is not surprising, then, that Corrington (1979) would find that this "spirituality" scale is correlated with life satisfaction. Factorially sound measures of spirituality exist and merit inclusion in broader clinical research (Spilka *et al.*, 1985; Shafranske, 1996). One thing that does seem clear is that spirituality is multi-dimensional (Larson, 1998). Efforts to measure even the more limited concept of religiosity or religious involvement have consistently pointed to multiple, relatively orthogonal factors (King, 1967; Hilty, 1988; Richards & Bergin, 1997).

Perhaps the most important thing we can do to promote research on spirituality, however, is to develop and contribute strong science in this area. One small but useful step in this direction is to begin including spiritual dependent and predictor variables in mainstream clinical research (Miller & Martin, 1988; Benner, 1991). This is already beginning to happen in the addiction field. Project MATCH (1993, 1997), for example, included several spiritual measures as well as one explicitly spiritual treatment condition (Nowinski *et al.*, 1992). One way to overcome the current state of affairs that excludes spiritual variables from biopsychosocial research is simply to begin measuring relevant dimensions as part of larger ongoing lines of research. My hope, however, is that spirituality will increasingly become the *central* subject of new lines of research.

Promising directions

Finally, I would like to point to a few topics that seem to me promising avenues for future research on spirituality and addictions. One tried and true principle is that if you want to study a phenomenon, go to where it is happening. In the addiction field, this certainly points one in the direction of AA. Despite some stereotypes, there is no prohibition against research within AA. In fact, AA has an official memo written by Bill Wilson encouraging members to cooperate with researchers, and many types of studies are possible (McCrady & Miller 1993). AA is so prevalent that clinical research is imperiled if AA involvement is not considered as a factor in treatment outcome, yet this is a very limited way of thinking—to view AA as a source of noise to be eliminated. The seldom-accepted challenge is to try to "hear the noise" (Edwards *et al.*, 1992), and understand the extra-treatment processes that affect recovery. It would be useful to understand the spiritual variables, the processes that predict recovery and response to treatment.

Viewed in this way, AA points us toward some specific "active ingredients" that may play a key role in recovery. These are traits more often thought of as character rather than as personality. Although these themes can be understood from a psychological perspective, they have often been overlooked by researchers and have more frequently been the province of spiritual professionals. One such theme long emphasized by AA (1939) is *acceptance*, which represents a conceptual opposite of trying to take charge and control (Baugh, 1988; Hayes *et al.*, 1995). It is a long-recognized spiritual paradox that acceptance of the present opens the door to change. Carl Rogers (1957) discussed acceptance of the client's (and of one's own) present experience as a necessary condition for change. More recently,

Marlatt (1995) has commended an accepting rather than controlling style as optimal for managing addictions. There is now persuasive evidence that an accepting, empathic helping style significantly promotes recovery (Miller, Taylor & West, 1980; Valle, 1981; cf. Miller & Rollnick, 1991).

In relation to this, the virtue of *humility* has been central in AA's understanding of the process of recovery (Kurtz & Ketcham, 1992). At the other extreme, self-absorption and an exaggerated need for control are health risk factors (Martin & Carlson, 1988). How does one measure humility? Probably not by asking people whether they have it!

The practice of *forgiveness* is associated with higher life satisfaction in general, and with religious involvement in particular (Poloma & Gallup, 1991), and is a concept with substantial therapeutic potential (Richards & Potts, 1995). Its opposites—resentment, impatience, and hostility—have been inversely associated with health (Johnson, 1990), and are frequently warned against as obstacles to recovery. Forgiveness sometimes figures prominently in stories of recovery (e.g. H. & McPeek, 1988), and is a little-studied process well worth studying more carefully.

These processes lead us back to the possibility of integrating spiritual themes and approaches in professional treatment. Rebecca Propst (1980, 1992) has demonstrated in well-controlled trials that incorporation of the client's spiritual themes into treatment can significantly increase the efficacy of cognitive therapy for depression. For religiously orientated people, in fact, failure to take spiritual material into consideration could be a significant obstacle to change (Miller, 1988). In this regard, it would also be helpful to know more about how specific spiritual dimensions, such as one's concept of God, affect treatment and recovery (cf. Miller & Thoresen, 1998; Gorsuch, 1995).

A further step is to test treatment methods that are explicitly spiritual and meaning-focused. As described above, randomized trials have already tested meditation, prayer and a treatment designed to involve the client in the Twelve Steps. Brown & Peterson (1990a) have described a value-based and testable treatment model for addictions. They have also described the types of changes in values that are associated with recovery (Brown & Peterson, 1990b), which in many ways resemble the value shifts that we have reported to be associated with quantum changes more generally (Miller & C'de Baca, 1994).

When venturing into research on spirituality, of course, one is not without critics. Secular colleagues may aver that these are not proper topics for professional treatment or scientific investigation. Religious observers may be equally appalled at such research, persuaded that it is inappropriate to try to view spirituality through scientific lenses. There are those who, for either of these or other reasons, protest that public funds should never be used to evaluate spiritually rooted treatments. However, there is no reason why an entire class of potential healing agents must be excluded from scientific investigation. The whole enterprise that is now psychotherapy was, not long ago, almost exclusively the province of clergy (Pattison, 1978). The compassionate mission of healing is surely our common and most important professional purpose. For as long as history has been recorded, people have found spirituality to be a significant source of healing. A large proportion of people continue to find spirituality, including religious involvement, to be an important source of meaning and sustenance. Simply to ignore a major potential source of healing violates both scientific curiosity and professional responsibility. It is time to question and reverse the assumption that spiritual variables are taboo for scientists and therapists, or that scientific methods cannot possibly shed light on spirituality. Similar mystery once surrounded psychotherapy (and still does for some) in the belief that its art was so complex and its outcomes so subtle and sublime as to elude the scientific method. Psychotherapy research now fills journals and is a specialty in itself. We routinely address and integrate the biological, psychological and social aspects of addiction and other mental health problems. Why not move toward models of health and treatment that include the spiritual side of humanity as well?

Acknowledgement

Preparation of this manuscript was supported in part by grant number K05-AA00133 from the US National Institute on Alcohol Abuse and Alcoholism.

References

ADVISORY COUNCIL ON CHURCH AND SOCIETY, PRESBYTERIAN CHURCH (1986) *Alcohol Use and Abuse: the social and/health effects* (New York, The Program Agency, Presbyterian Church).

ALBAUGH, B. J. & ANDERSON, P. O. (1974) Peyote in the treatment of alcoholism among American Indians, *American Journal of Psychiatry*, 131, 1247–1250.

ALCOHOLICS ANONYMOUS (1939) *Alcoholics Anonymous* (New York, Works Publishing).

AMERICAN PSYCHIATRIC ASSOCIATION (1994) *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn (Washington, DC, Author).

ARCINIEGA, L. T. & MILLER, W. R. (1997) Where to publish? Characteristics of addiction journals. *Addiction*, 92, 1639–1648.

ARON, A. & ARON, E. N. (1980) The transcendental meditation program's effect on addictive behavior, *Addictive Behaviors*, 5, 3–12.

BARLOW, D. H., ABEL, G. G. & BLANCHARD, E. G. (1977) Gender identity change in a transsexual: an exorcism, *Archives of Sexual Behavior*, 6, 387–395.

BAUGH, J. R. (1988) Gaining control by giving up control: strategies for coping with powerlessness, in: MILLER, W.R & MARTIN, J.E (Eds) *Behavior Therapy and Religion: integrating spiritual and behavioral approaches to change*, pp. 125–138 (Newbury Park, CA, Sage Publications).

BENNER, D. G. (1991) Understanding, measuring, and facilitating spiritual well-being: introduction to a special issue, *Journal of Psychology and Theology*, 19, 3–5.

BERGIN, A. E. (1980) Psychotherapy and religious values, *Journal of Consulting and Clinical Psychology*, 48, 95–105.

BERGIN, A. E. (1983) Religiosity and mental health: a critical reevaluation and meta-analysis, *Professional Psychology: Research and Practice*, 14, 170–184.

BERGIN, A. E. & JENSEN, J. P. (1990) Religiosity of psychotherapists: a national survey, *Psychotherapy*, 27, 3–7.

BIEN, T. H., MILLER, W. R. & TONIGAN, J. S. (1993) Brief interventions for alcohol problems: a review, *Addiction*, 88, 315–336.

BLACK, W. A. (1991) An existential approach to self-control in the addictive behaviours, in: HEATHER, N., MILLER, W. R. & GREELEY, J. (Eds) *Self-control and the Addictive Behaviours*, pp. 262–279 (Sydney, Maxwell-MacMillan Publishing Australia).

BROWN, H. P. JR & PETERSON, J. H. JR (1990a) Rationale and procedural suggestions for defining and actualizing spiritual values in the treatment of dependency, *Alcoholism Treatment Quarterly*, 7, 17–46.

BROWN, H. P. JR & PETERSON, J. H. JR (1990b) Values and recovery from alcoholism through Alcoholics Anonymous, *Counseling and Values*, 35, 63–68.

BROWN, H. P., JR PETERSON, J. H. JR & CUNNINGHAM, O. (1988) An individualized behavioral approach to spiritual development for the recovering alcoholic/addict, *Alcoholism Treatment Quarterly*, 5, 177–196.

CLEMENT, P. (1978) Getting religion, *APA Monitor*, 9, 2.

CLINEBELL, H. J. JR (1956) *Understanding and Counseling the Alcoholic Through Religion and Psychology* (New York, Abingdon Press).

CLINEBELL, H. J. (1963) Philosophical-religious factors in the etiology and treatment of alcoholism, *Quarterly Journal of Studies on Alcohol*, 24, 473–484.

CONNORS, G. J., TONIGAN, J. S. & MILLER, W. R. (1996) A measure of religious background and behavior for use in behavior change research, *Psychology of Addictive Behavior*, 10, 90–96.

CORRINGTON, J. E. (1989) Spirituality and recovery: relationships between levels of spirituality, contentment, and stress during recovery from alcoholism in AA, *Alcoholism Treatment Quarterly*, 6, 151–165.

CRUMBAUGH, J. C. & MAHOLICK, L. T. (1964) An experimental study in existentialism: the psychometric approach to Frankl's concept of noogenic neurosis, *Journal of Clinical Psychology*, 22, 200–207.

CRUMBAUGH, J. C. & MAHOLICK, L. T. (1969) *The Purpose in Life Test* (Chicago, IL, Psychometric Affiliates).

DOSSEY, L. (1993) *Healing Words: the power of prayer and the practice of medicine* (San Francisco, Harper).

EDWARDS, G. & GROSS, M. M. (1976) Alcohol dependence: provisional description of a clinical syndrome, *British Medical Journal*, 1, 1058–1061.

EDWARDS, G., OPPENHEIMER, E. & TAYLOR, C. (1992) Hearing the noise in the system: exploration of textual analysis as a method for studying change in drinking behavior, *British Journal of Addiction*, 87, 73–81.

ELLISON, C. W. & SMITH, J. S. (1991) Toward an integrative measure of health and well-being, *Journal of Psychology and Theology*, 19, 35–48.

EMRICK, C. D., TONIGAN, J. S., MONTGOMERY, H. & LITTLE, L. (1993) Alcoholics Anonymous: what is currently known? in: MCCRADY, B. S. & MILLER, W. R. (Eds) *Research on Alcoholics Anonymous: opportunities and alternatives*, pp. 41–76 (New Brunswick, NJ, Rutgers Center of Alcohol Studies).

FINNEY, J. R. & MALONY, H. N. JR (1985) Empirical studies of Christian prayer: a review of the literature, *Journal of Psychology and Theology*, 13, 104–115.

GARTNER, J., LARSON, D. B. & ALLEN, G. (1991) Religious Commitment and mental health: a review of the empirical literature, *Journal of Psychology and Theology*, 19, 6–25.

GORSUCH, R. L. (1995) Religious aspects of substance abuse and recovery, *Journal of Social Issues*, 51, 65–83.

GORSUCH, R. L. & BUTLER, M. C. (1976) Initial drug abuse: a review of predisposing social psychological factors, *Psychological Bulletin*, 83, 120–137.

H., A. & MCPEEK, G. (1988) *The Grieving Indian: an Ojibwe elder shares his discovery of help and hope* (Winnipeg, Indian Life Books).

HAYES, S. C., JACOBSON, N. S., FOLLETTE, V. M. & DOUGHER, M. J. (Eds) (1995) *Acceptance and Change: content and context in psychotherapy* (Reno, NV, Context Press).

HILTON, M .E. (1991) The demographic distribution of drinking problems in 1984, in: CLARK, W. B. & HILTON, M. E. (Eds) *Alcohol in America: drinking practices and problems*, pp. 87–101 (Albany, NY, State University of New York Press).

HILTY, D. M. (1988) Religious belief, participation and consequences: an exploratory and confirmatory analysis, *Journal for the Scientific Study of Religion*, 27, 243–259.

HORN, J. L., WANBERG, K. W. & FOSTER, F. M. (1987) *Guide to the Alcohol Use Inventory* (Minneapolis, National Computer Systems).

ICHIYAMA, M. A., ZUCKER, R. A., NYE, C. L., BINGHAM, C. R., BROUWER, R. D. & FITZGERALD, H. E. (1995) Women married to alcoholic men: characteristics of a community sample, *Alcoholism: Clinical and Experimental Research*, 19, 542.

JAMES, W. (1902) *Varieties of Religious Experience* (New York, Longmans, Green).

JOHNSON, E. H. (1990) *The Deadly Emotions: the role of anger, hostility, and aggression in health and emotional well-being* (New York, Praeger).

JUNG, C. J. (1961/1975) Letter to William G. Wilson, 30 January, 1961, in: ADLER, G. (Ed.) *Letters of Carl G. Jung*, vol. 2, pp. 623–625 (London, Routledge & Kegan Paul).

KING, M. B. (1967) Measuring the religious variable: nine proposed dimensions, *Journal for the Scientific Study of Religion*, 6, 173–190.

KOENIG, H. G., GEORGE, L. K., MEADOR, K. G., BLAZER, D. G. & FORD, S. M. (1994) Religious practices and alcoholism in a southern adult population, *Hospital and Community Psychiatry*, 45, 225–231.

KURTZ, E. (1979) *Not God: a history of Alcoholics Anonymous* (Center City, MN, Hazelden).

KURTZ, E. & KETCHAM, K. (1992) *The Spirituality of Imperfection: modern wisdom from classic stories* (New York, Bantam Books).

LARSON, D. C., SWYERS, J. P. & MCCULLOUGH, M. E. (Eds) (1998) *Scientific Research on Spirituality and Health: a consensus report* (Rockville, MD, National Institute for Healthcare Research), in press.

LARSON, D. B. & WILSON, W. P. (1980) Religious life of alcoholics, *Southern Medical Journal*, 73, 723–727.

LARSON, D. B., PATTISON, E. M., BLAZER, D. G., OMRAN, A. R. & KAPLAN, B. H. (1986) Systematic analysis of research on religious variables in four major psychiatric journals, 1978–1982, *American Journal of Psychiatry*, 143, 329–334.

LARSON, D. B., SHERRILL, K. A. & LYONS, J. S. *et al.* (1992) Associations between dimensions of religious commitment and mental health reported in the *American Journal of Psychiatry* and *Archives of General Psychiatry*: 1978–1989, *American Journal of Psychiatry*, 149, 557–559.

LEVIN, J. S. (1994) Religion and health: is there an association, is it valid, and is it causal? *Social Science and Medicine*, 38, 1475–1482.

LEVIN, J. S. & VANDERPOOL, H. Y. (1987) Is frequent religious attendance *really* conducive to better health? Toward an epidemiology of religion, *Social Science and Medicine*, 24, 589–600.

LYTTLE, T. (1988) Drug based religions and contemporary drug taking, *Journal of Drug Issues*, 18, 271–284.

MÄKELÄ, K. (1975) Consumption level and cultural drinking patterns as determinants of alcohol problems, *Journal of Drug Issues*, 5, 344–357.

MARLATT, G. A. (1995) Addiction, mindfulness, and acceptance, in: HAYES, S. C., JACOBSON, N. S., FOLETTE, V. M. & DOUGHER, M. J. (Eds) *Acceptance and Change: content and context in psychotherapy*, pp. 175–197 (Reno, NV, Context Press).

MARLATT, G. A. & KRISTELLER, J. (1998) Mindfulness and meditation, in: MILLER, W. R. (Ed.) *Integrating Spirituality in Treatment: resources for practitioners* (Washington, DC, American Psychological Association), in press.

MARLATT, G. A. & MARQUES, J. K. (1977) Meditation, self-control and alcohol use, in: STUART, R. B. (Ed.) *Behavioral Self-management: strategies, techniques and outcome*, pp. 117–153 (New York, Brunner/Mazel).

MARTIN, J. E. & BOOTH, J. (1998) Behavioral approaches to enhance spirituality, in: MILLER, W. R. (Ed.) *Integrating Spirituality in Treatment: resources for practitioners* (Washington, DC, American Psychological Association), in press.

MARTIN, J. E. & CARLSON, C. R. (1988) Spiritual dimensions of health psychology, in: MILLER, W. E. & MARTIN, J. E. (Eds) *Behavior Therapy and Religion: integrating spiritual and behavioral approaches to change*, pp. 57–110 (Newbury Park, CA, Sage Publications).

MATTHEWS, D. A., LARSON, D. A. & BARRY, C. (1993) *The Faith Factor: an annotated bibliography of clinical research on spiritual subjects*, vol. 1 (Rockville, MD, National Institute for Healthcare Research).

MAY, G. G. (1991) *Addiction and Grace: love and spirituality in the healing of addictions* (New York, Harper).

MCCRADY, B. S. & MILLER, W. R. (1993) *Research on Alcoholics Anonymous: opportunities and alternatives* (New Brunswick, NJ, Rutgers Center of Alcohol Studies).

MCLELLAN, A. T., PARIKH, G., BRAGG, A., CACCIOLA, J., FUREMAN, B. & INCMIKOFKI, R. (1990) *Addiction Severity Index Administration Manual*, 5th edn (Philadelphia, Penn-VA Center for Studies of Addiction).

MILLER, W. R. (1988) Including clients' spiritual perspectives in cognitive behavior therapy, in: MILLER, W. R. & MARTIN, J. E. (Eds) *Behavior Therapy and Religion: integrating spiritual and behavioral approaches to change*, pp. 43–55 (Newbury Park, CA, Sage Publications).

MILLER, W. R. (1990) Spirituality: the silent dimension in addiction research. The 1990 Leonard Ball oration, *Drug and Alcohol Review*, 9, 259–266.

MILLER, W. R. (1995) Toward a biblical view of drug use, *Journal of Ministry in Addiction and Recovery*, 2, 77–86.

MILLER, W. R. & BENNETT, M. E. (1997) Toward better research on spirituality and health: the Templeton panels, *Spiritual and Religious Issues in Behavior Change*, 10, 3–4.

MILLER, W. R. & C DE BACA, J. (1994) Quantum change: toward a psychology of transformation, in: HEATHERTON, T. & WEINBERGER, J. (Eds) *Can Personality Change?* pp. 253–280 (Washington, DC, American Psychological Association).

MILLER, W. R. & HESTER, R. K. (1995) Treatment for alcohol problems: toward an informed eclecticism,

in: HESTER, R. K. & MILLER, W. R. (Eds) *Handbook of Alcoholism Treatment Approaches*, 2nd edn, pp. 1–11 (Boston, MA, Allyn & Bacon).

MILLER, W. R. & KURTZ, E. (1994) Models of alcoholism used in treatment: contrasting A. A. and other perspectives with which it is often confused, *Journal of Studies on Alcohol*, 55, 159–166.

MILLER, W. R. & MARLATT, G. A. (1984) *Manual for the Comprehensive Drinker Profile* (Odessa, FL, Psychological Assessment Resources).

MILLER, W. R. & MARTIN, J. E. (1988) Spirituality and behavioral psychology, in: MILLER, W. R. & MARTIN, J. E. (Eds) *Behavior Therapy and Religion: integrating spiritual and behavioral approaches to change*, pp. 13–23 (Newbury Park, CA, Sage Publications).

MILLER, W. R. & ROLLNICK, S. (1991) *Motivational Interviewing: preparing people to change addictive behavior* (New York, Guilford Press).

MILLER, W. R., TAYLOR, C. A. & WEST, J. C. (1980) Focused versus broad spectrum behavior therapy for problem drinkers, *Journal of Consulting and Clinical Psychology*, 48, 590–601.

MILLER, W. R. & THORESEN, C. E. (1998). Spirituality and health, in: MILLER, W. R. (Ed.) *Integrating Spirituality in Treatment: resources for practitioners* (Washington, DC, American Psychological Association), in press.

MONTGOMERY, H. A., MILLER, W. R. & TONIGAN, J. S. (1993) Differences among AA groups: implications for research, *Journal of Studies on Alcohol*, 54, 503–504.

MONTGOMERY, H. A., MILLER, W. R. & TONIGAN, J. S. (1995) Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment*, 12, 241–246.

MOOKHERJEE, H. N. (1986) Comparison of some personality characteristics of male problem drinkers in rural Tennessee, *Journal of Alcohol and Drug Education*, 31, 23–28.

MUFFLER, J., LANGROD, J. & LARSON, D. (1995) "There is a balm in Gilead": religion and substance abuse treatment, in: LOWINSON, J. H., RUIZ, P., MILLMAN, R. B. & LANGROD, J. G. (Eds) *Substance Abuse: a comprehensive textbook*, 2nd edn, pp. 584–595 (Baltimore, MD, Williams & Wilkins).

MURPHY, T. J., PAGANO, R. R. & MARLATT, G. A. (1986) Lifestyle modification with heavy alcohol drinkers: effects of aerobic exercise and meditation, *Addictive Behaviors*, 11, 175–186.

NOWINSKI, J., BAKER, S. & CARROLL, K. (1992) *Twelve Step Facilitation Therapy Manual: a clinical research guide for therapists treating individuals with alcohol abuse and dependence*, vol. 1, Project MATCH Monograph Series, (Rockville, MD, National Institute on Alcohol Abuse and Alcoholism).

PARGAMENT, K. I. (1998) *The psychology of religion and coping* (New York, Guilford Press), in press.

PATTISON, E. M. (1978) Psychiatry and religion circa 1978: analysis of a decade, part I, *Pastoral Psychology*, 27, 8–25.

POLOMA, M. M. & GALLUP, G. H. JR (1991) *Varieties of Prayer: a survey report* (Philadelphia, Trinity Press).

PROJECT MATCH RESEARCH GROUP (1993) Project MATCH: rationale and methods for a multisite clinical trial matching patients to alcoholism treatment, *Alcoholism: Clinical and Experimental Research*, 17, 1130–1145.

PROJECT MATCH RESEARCH GROUP (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes, *Journal of Studies on Alcohol*, 58, 7–29.

PROPST, L. R. (1980) The comparative efficacy of religious and nonreligious imagery for the treatment of mild depression in religious individuals, *Cognitive Therapy and Research*, 4, 167–178.

PROPST, L. R., OSTROM, R., WATKINS, P., DEAN, T. & MASHBURN, D. (1992) Comparative efficacy of religious and nonreligious cognitive–behavioral therapy for the treatment of clinical depression in religious individuals, *Journal of Consulting and Clinical Psychology*, 60, 94–103.

RICHARDS, P. S. & BERGIN, A. E. (1997) *A Spiritual Strategy for Counseling and Psychotherapy*, (Washington, DC, American Psychological Association).

RICHARDS, P. S. & POTTS, R. W. (1995) Using spiritual interventions in psychotherapy: practices, successes, failures, and ethical concerns of Mormon psychotherapists, *Professional Psychology: Research and Practice*, 26, 163–170.

ROGERS, C. R. (1957) The necessary and sufficient conditions for therapeutic personality change, *Journal of Consulting Psychology*, 21, 95–103.

SHAFRANSKE, E. P. (1996) Religious beliefs, affiliations, and practices of clinical psychologists, in: SHAFRANSKE, E. P. (Ed.) *Religion and the Clinical Practice of Psychology*, pp. 149–162 (Washington, DC, American Psychological Association).

SPILKA, B., HOOD, R. W., JR & GORSUCH, R. L. (1985) *The Psychology of Religion: an empirical approach* (Englewood Cliffs, NJ, Prentice-Hall).

TUCHFELD, B. S. (1981) Spontaneous remission in alcoholics: empirical observations and theoretical implications, *Journal of Studies on Alcohol*, 42, 626–641.

VALLE, S. K. (1981) Interpersonal functioning of alcoholism counselors and treatment outcome, *Journal of Studies on Alcohol*, 42, 783–790.

WALKER, S. R., TONIGAN, J. S., MILLER, W. R., COMER, S. & KAHLICH, L. (1997) Intercessory prayer in the treatment of alcohol abuse and dependence: a pilot investigation, *Alternative Therapies*, 3, 79–86.

WALTERS, O. S. (1957) The religious background of 50 alcoholics, *Quarterly Journal of Studies on Alcohol*, 18, 405–413.

WHITFIELD, C. L. (1984) Stress management and spirituality during recovery: a transpersonal approach, Part 1: Becoming, *Alcoholism Treatment Quarterly*, 1, 3–54.

Bateman, Nils I.//Peterson, David M.
Variables related to outcome of treatment for hospitalized alcoholics
International Journal of the Addictions
June 1971
6
2
215-224
Cited by Bebbington as finding 'that prior (and by implication, failed) attendance at AA has been a predictor of success for subsequent programmes.'
Investigates 'non-clinical factors' at a state rehab center in the U.S. South; weekly AA meetings were provided for the patients. Main variables = 'a previous history of regular attendance at AA, mother deceased, and for those with mothers living, contact less frequently than monthly.'

Fagan, R.W.//Mauss, A.L.
Social margin and social reentry: An evaluation of a rehabilitation program for skid row alcoholics
Journal of Studies on Alcohol
1986
47
413-425
[Pisani et al.]: demonstrated that patients who attend more AA meetings in the early months following discharge fare much better with respect to abstinence.

Erickson, L.//Stout, J. K.//Williams, J. M.
Comparison of the Importance of Alcoholics Anonymous and Outpatient Counseling to Maintenance of Sobriety Among Alcohol Abusers
Psychological Reports
1986
58
3
803-806
[NCADI]: Alcoholics' self-reported rating of the importance of AA to maintenance of sobriety was assessed. Thirty-six individuals, 24 men and 12 women, ranging in age from 19 to 61 years, who were enrolled in the alcoholism rehabilitation program in the State of New York, volunteered to participate in the study. They drank 5 to 15 drinks a day during a one month period immediately prior to becoming sober and their drinking histories ranged from 2 to 11 years. AA was rated significantly higher in importance to maintenance of sobriety by participants with above median days (160 days) of sobriety than those with below median days of sobriety or than outpatient counseling by those with below or above median days of sobriety. A significant, positive correlation of 0.79 between attendance at AA and days of sobriety was found. It is suggested, however, that more direct evaluation of the role of AA in promoting sobriety is needed before firm conclusions can be drawn. The authors cite 18 references.

McTimoney, D.C.//Campbell, E.S.//Cooper, R.H.
Factors Influencing A.A. and Treatment Outcome: A Descriptive Paper
(Presented at the 2nd Annual Meeting of the Special Interest Group on Program Evaluation, Canadian Addiction Foundation, Regina, SASK, Canada, September 8-9, 1982)

The results of a times series evaluation of alcoholic clients treated at the Alcoholism & Drugs Dependency Commision of New Brunswick, Canada, facilities to determine whether there are differences between clients who affiliated with Alcoholics Anonymous and those who do not join AA. Clients were interviewed at baseline, 3, 6, & 12 months. It was found that: (1) at 12 months, a higher proportion (56%) of AA affiliates were married, and better than one-half reported active religious participation, compared to 16% of non-AA's; (2) a higher proportion of AA's than non-AA's reported a job was their major means of financial support; (3) at baseline, one-third of AA's reported having a job, while one-half reported having a job at 12 months; (4) drinking every day declined over time for both groups, with AA's reporting a smaller proportion of daily drinkers (10%) than did the non-AA's (21%); although drug use declined over time for both groups, a higher proportion of AA's continue to use drugs other than alcohol. In summary, this study obviously makes the point it's better to be in AA than not.

Morgan, Oliver J.
Extended Length Sobriety: The Missing Variable
Alcoholism Treatment Quarterly
1995
12
1
69-71

[EK]: After noting, and somewhat reviewing, how the literature on recvoery gives scant attention to recovery over the long-term, suggests the benefits of such research and outlines an ongoing exploratory project which utilizes this variable.

'I have been unable to find a single research study that gives sustained attention to extended-length-of-continuous-and-abstinent-sobriety as a primary variable for research, despite titles that might indicate otherwise.'

Under 'Re-Visioning of Self': 'Without exception these persons portray degradation and loss of self as a crucial theme in understanding their life stories.'

Under 'Re-Visionion of Life-Context': 'The lives of these persons are grounded in confidence about the ongoing care of their Higher Power. That is, they experience and expect that their lives are enfolded by care; they understand their lives as secured and guided by 'providence.' They experience 'miracles; happening in their lives and expect that 'coincidences' are no longer coincidental. They expect good things to happen for themselves and those they love even in the midst of hardship. These are core beliefs that support them in good times and sustain them in hard times. This way of construing their lives is a central theme in successful, long-term recovery experience.'

'This research in progress indicates that the important factors in the development of recovery over time include cognitive and attitudinal re-visioning both of self and life-context, and behavioral restructuring of lifestyle.'

Vaillant, George E.
What Can Long-term Follow-up Teach Us About Relapse and Prevention of Relapse in Addiction?
British Journal of Addiction - 1988
83 (10)
1147-1157

[Journal]: Reviews the treatment history of 100 hospital-treated heroin addicts and 100 hospital-treated alcohol-dependent individuals. The two cohorts were prospectively followed for 20 and 12 years respectively and factors related to relapse and freedom from relapse were sought. Premorbid social stability, especially stable employment history, proved a more effective predictor of long-term outcome than the severity or chronicity of addiction. Inpatient treatment exerted little effect on long-term course. For both samples, encountering one or more of the following -- community compulsory superivison, a substitute dependence, new relationships, and inspirational group membership -- appeared associated with freedom from relapse. The challenge of preventing relapse in diabetes is offered as a useful analogy for preventing relapse in the addictions.

[Text]: Within 2 years after leaving the hospital 95% of both groups of patients had relapsed. But if 95% of the alcoholics relapsed to alcohol dependence -- a criterion often used to indicate treatment failure -- at some point 59% of the same 100 patients achieved at least 6 months of abstinence -- a criterion often used to indicate recovery. Thus, a majority of our alcoholics could have been classified as both treatment successes and treatment failures. To clarity such confusion the dimension of time must be attended to.

'During recovery it is probably valuable for alcoholics to form bonds with people they have not hurt in the past. In this regard an AA sponsor of a new spouse may be more useful than the dyadic relationship with a long-suffering family member, which must repeatedly re-awaken old guilts and old angers -- conditioned reinforcers of alcohol use.'

'Table 7 illustrates that the strong association of AA utilization with remission . . . cannot be attributed to premorbid social stability (as 1975 studies by Baekeland et al. and Costello suggested). Frequent AA attendance may have played a causal role in both social and clinical improvement.' Suggests viewing AA in terms of Jerome Frank's Persuasion and Healing.

[Conclusion]: We must cease to conceptualize drug addiction as a more or less conscious use of an active drug in order to provide either emotional solace or exquisite self indulgence. If instead we conceive of drug addiction as a whole constellation of conditioned, unconscious behaviours, then the relative success of parole, methadone maintenance and AA over conventional intervention begins to make sense. These community interventions serve to impose a structure on the addict's life. This structure interferes with drug-seeking behaviour based upon conditioned withdrawal symptoms and upon conditioned reinforcers like the ritual of 'belting up,' the friendship of hard drinking friends and the experience of purposeful behaviorus that precedes self-medication.

All this important in light of controlled studies and literature reviews that suggest that prolonged 2- to 4-week inpatient treatment of alcohooism achieves results no better than those obtained by outpatient treatment advice or brief detoxification. The goal of treatment is not detoxification but prevention of relapse.

Gorsuch, Richard L.
Assessing Spiritual Variables in Alcoholics Anonymous Research
in
McCrady, Barbara S.//Miller, William R.
eds.
Research on Alcoholics Anonymous: Opportunities and Alternatives
New Brunswick, NJ
Rutgers Center of Alcohol Studies
1993
301-318

301: Despite the importance of spirituality in AA's 12 steps, addiction research has seldom measured spirituality [!]. The purpose of this chapter is first to examine several definitions of spirituality that might be important for measuring this facet of AA. The empirical relationships of these measures to alcohol abuse will then be summarized and the theoretical relationship of spirituality to addiction and AA will be explored from a psychological perspective. Finally, a methodological point will be made that is essential if spirituality as an intervention is to be properly evaluate.

302: The most prominent tradition of measurement in the psychology of religion has been that of the intrinsic/extrinsic (I/E) motivation distinction introduced by Allport and reviewed by Donahue. Intrinsicness is defined as being religious for the sake of being religious and not to fulfill any other need or value. Extrinsicness is defined as being religious for some other reason, such as to develop social relationships or to gain personal comfort in a time of crisis.

302: Another popular way of measuring religious commitment and by implication spirituality is to ask for reported behaviors.

304 [after much on questions involving "religion"]: Spirituality as a term is, however, used in a considerably broader sense than that discussed so far. Spirituality in this sense appears to be referring to people who are concerned with metaphysical issues as well as their daytoday lives. It need have no belief in God. Little research has been done with this construct and so there is no real tradition of measurement with it.

304: Berenson suggests that "spirituality, as opposed to religion, connotes a direct, personal experience of the sacred unmediated by particular belief systems prescribed by dogma or by hierarchical structure of priests, ministers, rabbis, or gurus." [Oh?! Seems to tell more of B's biases than of spirituality and what is the evidence?] While this is idealistic no experience is uninfluenced by one's past, personal belief systems, and expectancies it does clearly [?!] recognize a transcendent element not tied to one particular religion. This distinction does have an operation measure already in existence: Hood's scales of mystical experience. [Is it fair, accurate, to equate "spiritual" with "mystical"? cf. McGinn?]

309f: Under heading "Possible Roles of Spiritual Factors in Alcoholics Anonymous": "Alcoholism as the Failure of Spirituality."

309: ". . . it is conclusive that the classical religions of our culture Catholic, Jewish, and Protestant have been a major bulwark against alcohol abuse."

313: When [spirituality] has been studied, the operational definitions have made [it] so broad that the transcendent aspect has been ignored despite AA's focus on a higher power.

313: The distinction between religious institutions and spirituality does, however, seem to be oversimplified. Every human institution including treatment programs for alcoholics falls short of its ideologies. But the implication that imperfect religious institutions and their representatives are not helpful in treating alcoholics may be shortsighted. . . .

313-314: It seems to me that the split between religion and spirituality has at least two bases. The first basis is that AA is, of course, nondoctrinal. Being nondoctrinal should mean, in terms of AA and spirituality in the 12 steps, that the emphasis is place upon getting in touch with one's own spiritual roots in the tradition of one's choice. Second, AA attracts people for whom the classical religious institutions have not had the impact they have had with other people.

315-316: Note that must investigate changes in spiritual practice, etc., in sobriety.

[Author]: Despite the importance of spirituality in AA's 12 steps, addiction research has seldom measured spirituality. The purpose of this chapter is first to examine several definitions of spirituality that might be important for measuring this facet of AA. The empirical relationships of these measures to alcohol abuse will then be summarized and the theoretical relationship of spirituality to addiction and AA will be explored from a psychological perspective. Finally, a methodological point will be made that is essential if spirituality as an intervention is to be properly evaluated.

Humphreys, Keith
Psychotherapy and the Twelve-Step Approach for Substance Abusers: The Limits of Integration
Psychotherapy
Summer 1993
30
2
207-213

4: Distinguishes between "helping strategies the techniques a helper (professional or otherwise) employs to facilitate the resolution of problems" and "helping values deal with existential issues," shape the answers to questions such as "What should a person optimally be?" and "Why should we help others?" While helping values are not always articulated, they are always present in the therapeutic endeavor.

5: The helping strategies of twelve step groups can be incorporated into professional psychotherapy without any loss of integrity, while twelve step helping values usually cannot.

7: The helping values of followers of twelve step philosophy conflict with those of professional psychotherapists in a number of areas. [Looks at: Indigenous vs. Professional Leadership; (8) SelfAbasement vs. SelfEnhancement; (10) Experiential vs. Professional Knowledge; (11) Spiritual Enthusiasm vs. Spiritual Skepticism; (11) Free vs. Fee;

9: Most psychotherapists would agree that it is psychologically healthy for a substance abuser to accept that some things are beyond his control, particularly if he is extremely perfectionistic, anxious, or compulsive. Both therapists and twelve step group members see acknowledging the limits of human control as beneficial, but twelve step members see those limits as far more pervasive and impenetrable than do most professional helpers.

13: When fundamental value differences between communities arise, there is a tendency to assume that one group is necessarily inferior and that integration must occur to minimize the differences or to secure the triumph of one community over the other. I recommend an alternative perspective: vive la differance! The continued existence of psychotherapy and twelve step groups is strong evidence that each appeal to large numbers of people who have substance abuse problems. Eliminating the differences, even if it were possible, would only serve to reduce the choices for persons in need of aid.

13: Three principles should guide interactions between the twelve step and professional communities: autonomy, mutual respect, and cooperation.

14: One of the most basic features of any group of people that excludes others is language, and both twelve step organizations and therapists have mysterious argots that they use to describe substance abuse problems. Cooperation between the two parties would be enhanced if both took the time to learn, and to teach, their way of describing their constructions of reality. It is important that these exchanges be respectful, and not result in one language being understood as more basic than the other (i.e., "What you describe as your internal tapes is really your superego").

[PSYC]: Argues that while there is potential for successful blending of 12-step approaches and psychotherapies for chemical dependency at the level of helping strategies/techniques, some basic differences in values and philosophy will make it impossible to ever fully integrate the 2 approaches without compromising one or the other approach. Some of the differences between the 2 approaches involve leadership (indigenous vs professional), individual control (increasing vs decreasing), and spirituality (enhanced vs decreased). Given that psychotherapy and the 12-step approach must remain largely independent, a model for interactions based on mutual respect, independent control, and cooperation is suggested.

[Author]: While there is potential for successful blending of twelve step approaches and psychotherapies for chemical dependency at the level of helping strategies/techniques, some basic differences in values and philosophy will make it impossible to ever fully integrate the twelve step approach and psychotherapy without compromising one or the other approach.

Distinguishes between "helping strategies -- the techniques a helper (professional or otherwise) employs to facilitate the resolution of problems" and "helping values -- deal with existential issues," shape the answers to questions such as "What should a person optimally be?" and "Why should we help others?" While helping values are not always articulated, they are always present in the therapeutic endeavor.

The helping strategies of twelve step groups can be incorporated into professional psychotherapy without any loss of integrity, while twelve step helping values usually cannot.

One of the most basic features of any group of people that excludes others is language, and both twelve step organizations and therapists have mysterious argots that they use to describe substance abuse problems. Cooperation between the two parties would be enhanced if both took the time to learn, and to teach, their way of describing their constructions of reality. It is important that these exchanges be respectful, and not result in one language being understood as more basic thatn the other (i.e., "What you describe as your internal tapes is really your superego").

Carroll, Stephanie
Spirituality and purpose in life in alcoholism recovery
Journal of Studies on Alcohol
May 1993
54
3
297-301

This study examines the relationship between spirituality and recovery from alcoholism. Spirituality was defined as the extent of practice of Alcoholics Anonymous Steps 11 and 12 and was measured by a Step Questionnaire developed by the researcher. Step 11 suggests prayer and meditation and Step 12 suggests assistance of other alcoholics. Expressed degree of purpose in life was also seen as a reflection of spirituality. It was postulated that the extent to which Steps 11 and 12 were practiced would be positively correlated with the extent of purpose in life reported by 100 Alcoholics Anonymous members. The major findings of this study are significant positive correlations between practice of Step 11 and purpose in life scores ($r = .59$, $p < .001$) and between Step 11 and length of sobriety ($r = .25$, $p < .01$). Number of Alcoholics Anonymous meetings attended was significantly correlated with purpose in life scores ($r = .24$, $p < .01$) and length of sobriety ($r = .25$, $p < .01$). These findings suggest that a sense of purpose in life increases with continuing sobriety and practice of the spiritual principles of Alcoholics Anonymous.

Alford, Geary S.
Alcoholics Anonymous: An Empirical Outcome Study
Addictive Behaviors
1980
5
359-370

[Beckman]: 27 male and 29 female alcoholics who had completed in-patient treatment program based on AA principles; substantially higher outcome rathes for females (61% of women and 30% of men were abstinent, productively functioning, and socially stable at one year follow-up); had three follow-up contacts and considered patients who could not be followed up as treatment failures, data from multiple collaborative sources; more women attended AA and a greater number of meetings.

[PSYC]: 56 alcoholic patients who completed an inpatient Alcoholics Anonymous (AA) treatment program were followed-up for 2 yrs. Two sets of criteria of success were used: AA criteria, which require patients to be employed/productively functioning, and socially/civilly stable, and abstinent; and general criteria, which allow either abstinence or light-moderate drinking without evidence of abuse. 51, 45, and 49% met AA criteria of success at 6, 12, and 24 mo, respectively, while 53, 51, and 56% met the general criteria at respective follow-up intervals.

Beckman, Linda J.
Alcoholics Anonymous and Gender Issues
in
McCrady, Barbara S.//Miller, William R.
eds.
Research on Alcoholics Anonymous: Opportunities and Alternatives
New Brunswick, NJ
Rutgers Center of Alcohol Studies
1993
233-248

233: "I will consider the limited research on gender and AA; discuss research on alcoholism in women and how women alcoholics differ from their male counterparts; and summarize more general research in gender differences that has implications for various aspects of AA membership for women versus men."

234-235: "The assumptions generally made about gender differences are congruent with a positive [sic] empiricist model of research that restricts analysis to a few clearly observable unity of behavior. Unger suggests that such a model ignores the effects of social constructs such as social status and power on the research enterprise itself. She supports a much more reflexive model of research that involves understanding of the reciprocal and interactive relationship existing between the person and reality and, thus, between experimenter and subject. Such a model may be of direct relevance for research on spirituality and recovery processes that AA members experience."

239: Table (p. 238) of "the characteristics of women alcoholics that have implications for affiliation with and recovery in AA." "Previous research shows differences between female and male alcoholic patients in patterns of alcohol consumption, demographic characteristics, other diagnoses, and psychological characteristics. Women in treatment are more likely than men to show primary affective disorder and to experience greater marital and family instability. They are also more likely to have alcoholic spouses."

240: "Alcoholic women may have lower selfesteem than men, and they more frequently report that they drink when they feel powerless or inadequate. Alcoholic women also have more stable attributions for failure than alcoholic men or nonalcoholic women."

242: "AA may be an easier form of alcoholism treatment for women to enter than most other forms because it is free and anonymous. Some women may attend AA, at least initially, without telling families, spouses, and friends who have tried to dissuade them from the idea that they are alcoholic."

245: "Gender differences in psychological characteristics and social behavior exist among alcoholics. A key question is whether these differences are large enough in magnitude and significant in their impact on recovery processes. The somewhat better outcomes of women in treatment suggests they are."

246: "The interactions of gender roles, experiences in AA, and processes of change provide an untapped but fruitful area for future research. For instance, do women and men work each of the 12 steps in exactly the same manner? Do their 'stories' have similar themes? How are the themes presented in the 'stories' related to recovery?"

246 [conclusion]: "When I started out on the journey of discovery involved in writing this paper, as a feminist I probably would have agreed with Jean Kirkpatrick that women who have feelings of inadequacy, worthlessness, and powerlessness and are faced with different issues than men need samesex support groups and treatments that emphasize competence and selfefficacy, not powerlessness and humility. Moreover, women should not be overrepresented in AA compared to men. But having reviewed the literature and learned more about the processes of change in AA, I am much less confident about these conclusions. I not believe that AA, a fellowship originally designed by and composed primarily of men, appears to be equally or more effective for women than for men. There is not clear empirical evidence to suggest that certain types of women would fare better in other types of alcoholism treatment."

[Conclusion]: "When I started out on the journey of discovery involved in writing this paper, as a feminist I probably would have agreed with Jean Kirkpatrick that women who have feelings of inadequacy, worthlessness, and powerlessness and are faced with different issues than men need same-sex support groups and treatments that emphasize competence and self-efficacy, not powerlessness and humility. Moreover, women should not be overrepresented in AA compared to men. But having reviewed the literature and learned more about the processes of change in AA, I am much less confident about these conclusions. I not believe that AA, a fellowship originally designed by and composed primarily of men, appears to be equally or more effective for women than for men. There is not clear empirical evidence to suggest that certain types of women would fare better in other types of alcoholism treatment."

Vaillant, George E.
The Natural History of Alcoholism Revisited
Cambridge, MA
Harvard University Press
1995

[CORK]: This volume represents both a "re-printing", as well an up-dating and reflection on a now classic work in the alcohol field, one published fifteen year ago. Drawing upon the analysis of two major longitudinal studies, that work described the natural history of alcoholism (alcohol dependence.) The "new" edition is structured as a "reprint" of the previous edition, with new sections interspersed and clearly denoted providing a commentary on the earlier work, drawing upon new research in the field, further follow-up of subjects, and the author's reflections.
Copyright 1996, Project Cork Institute.

[EK]: Makes significant and well-marked additions to 1983 study, and includes replies to as well as reports of research since the earlier edition.

Humphreys, Keith//Moos, Rudolf H.
Reduced Substance-Abuse-Related Health Care Costs Among Voluntary Participants in Alcoholics Anonymous
Psychiatric Services
July 1996
47
7
709-713

[Journal]: Researchers in the San Francisco Bay Area found that persons who attend Alcoholics Anonymous (AA) rather than seek outpatient treatment for alcohol abuse had treatment costs that were 45 percent lower (a total of $1,826) over a three-year period than those who got professional treatment. The outcomes for the two groups were similar, even though those in the AA group initially had more serious problems with alcohol.

A total of 201 persons who had never attended AA or received alcohol treatment were recruited for the study. The 135 persons who chose to attend AA rather than obtain professional help did not differ significantly in gender, marital and employment status, race, and symptoms of alcohol dependence and depression from the 66 who chose professional help. However, AA attendees had lower incomes and had experienced more adverse consequences of drinking, suggesting somewhat worse prognoses for this group.

The authors emphasized that the value of AA and other self-help groups should not be considered only in terms of potential cost saving. Nor should cost-conscious employers and insurers coerce individuals to attend AA, because the benefits of AA are strongly related to voluntary participation.

Humphreys, Keith//Moos Rudolf H.//Finney, John W.
Life domains, alcoholics anonymous, and role incumbency in the 3-year course of problem drinking
Journal of Nervous and Mental Disease
August 1996
184
8
475-481

[MEDLINE]: This study examined the course of problem drinking among 439 individuals over 3 years, using a life domains perspective that distinguishes life stressors and social resources in different contexts. More severe chronic financial stressors both predicted and were predicted by more alcohol consumption and drinking-related problems. Among social resources, Alcoholics Anonymous was the most robust predictor of better functioning on multiple outcome criteria. Support from friends and extended family also predicted better outcomes; this effect was stronger for individuals who were low on primary role incumbency (i.e., who were unemployed and/or did not have a spouse/partner).

Mr. MICA. Thank you. And I thank each of our panelists for t
expert testimony today. I would like to start with a round of q
tioning. It appears that we're spending somewhere around $3.2
lion on drug treatment programs from the Federal Treasury. A
it appears from this GAO report that one of the problems tha
have in determining whether programs are successful or not is
measuring the effectiveness of drug treatment is a complex ur
taking and it involves a number of factors. We have also heard
timony here today that raises some questions about self-reports
Dr. Vereen, it's my understanding that most of the informa
we base our reports of success or our measure of success are
tained from self-reports of addicts; is that correct?

Mr. VEREEN. Yes, that is true. It is important to underst
though, that self-report is used to measure a number of health
comes. So, for example, I mentioned that the effectiveness of t
ment for drug abuse is comparable to that of diabetes. Most pe
do not stick with their treatment regime properly for the treati
of diabetes. Perhaps more than half do not follow their
ommended insulin intake. But, they self-report that they have
following the regime.

We do have new biological markers, for example, to measu
a person's sugar level has reached a high point. And it is an
grained problem that we have in studying health outcomes,
drug abuse treatment effectiveness is not alone. It is a prol
with trying to assess the outcomes of other treatments as well.

Mr. MICA. We've heard a couple of our witnesses testify to
fact that the least effective measure is a self-reporting. And
ticularly about addicts and the GAO study also raises quest
about self-reporting. Dr. Lillie-Blanton, did you want to tell me

Ms. LILLIE-BLANTON. I want to explain one of the differences
Vereen is correct when he says we use self-report routinel
measuring health outcomes. I think the difference when we're
ing about self-report of drug use is that we're measuring in
case an illegal activity. And when you're measuring an illegal a
ity, particularly an illegal activity that has serious consequer
the likehood of underreporting is high.

Now what we do know is that self-report is the least accu
when you are asking questions about the more stigmatized dr
For example, if you're asking information about cocaine or he
versus marijuana, you would find self-reports to be less accu
for the cocaine.

We also know that self-report is less accurate for current
use. In many cases, our studies, evaluating treatment, have a
for information on drug use in the previous year or past yea
we at least are not asking for information that we know is the l
likely to be accurate.

Mr. MICA. Well, we're taking most of our data from self-re
ing. We've also heard recommendations from experts that the
way to get data is through drug testing. That can give you
current information. And you've also just testified that the l
likely truthful response is going to deal with a current situa
a current abuse problem. So wouldn't it make sense that we
quire very objective drug testing, urine analysis, hair anal
something to see what the results are? Would that be correct?

Ms. LILLIE-BLANTON. We don't make a recommendation in our report on this issue. But we have in a previous report encouraged greater use of more objective measures of drug use. However, we think that there is more testing and development of the technology that needs to be done before we encourage routine use of hair testing.

Mr. MICA. So in supporting the expenditure of Federal taxpayer dollars in programs that we want to find out whether they're really successful or not, we should have a testing component?

Ms. LILLIE-BLANTON. Yes, some objective measures should be included.

Mr. MICA. One of the things that concerned me, as most of the data that appeared that we're using to determine how we're spending our money and what programs are funded, comes from this data which is a drug abuse treatment outcome study by the National Institute on Drug Abuse. And I have information. First of all, 56 percent of the subjects of the data study were on parole, and then we find that a random sample of the addicts who were urine-tested a year later in a random sample, up to 20 percent refused to take the test and a huge number who took the test failed after saying that they weren't using drugs.

So, I really become concerned about the basis of it—or the study basis that we're using, the information that we're getting and then the results. And again, the chart that's been brought here—any program where we spent billions of taxpayer dollars and we have a 50-percent success rate and we're not sure that we can even rely on those figures, we need to revisit. So I have some concerns.

Finally, I don't know about other programs that are private or faith-based, and yours in particular that you referred to as part of the Haymarket Center. But I have one in my locality, the House of Hope, and they run a 90-percent success rate, pretty well substantiated and documented success rate, whereas some of my secular programs have much lower success rate figures. What kind of a success rate do you attribute to your program, sir?

Mr. SOUCEK. Well, we have a study that shows that in Illinois, the typical success is around 40 percent of the people in any given program in Illinois will remain drug free after their initial treatment. With our population, we are slightly below that 40-percent mark in terms of recidivism. So we are doing better with our programs, with probably the toughest population to treat in Illinois, because we deal with the criminal justice population, we deal with the population that's the minority population, the population that typically comes from the housing projects.

There is a lot of coercion that gets people into treatment, whether it's coercion to stay in a living environment or because of the criminal justice system. So our programs fare slightly better in terms of recovery rates than the State as a whole.

Mr. MICA. What type of Federal funds do you receive?

Mr. SOUCEK. We receive Federal block grant dollars for our women and children services and pregnant women and postpartum women services. We receive a specialized program grant that I mentioned in my testimony for a 5-year study of women and children in long-term residential care.

Mr. MICA. What percentage of Federal funds is used?

Mr. SOUCEK. Our Federal funding is probably in the area of 30 to 35 percent of our budget.

Mr. MICA. OK. My time is expired, I would like to come back, but I would like to yield now to our ranking member.

Mr. BARRETT. Thank you, Mr. Chairman. Inevitably when you have a report like this, the question arises as to whether we are using our resources effectively. And even without a report like this; oftentimes here in Congress a debate that occurs is where the money should be spent. It's a pie; how do you divide the pie? Should more resources be put into incarceration, should more resources be put into treatment, should more reresources be put into prevention programs, should more resources be put into border programs?

The question I have for each of you is, do you feel as we divide up that pie, based on either this report or your own experiences, that we should be cutting the treatment dollars, either as an absolute figure or as a percentage of the pie? And I would start with you, Dr. Vereen.

Dr. VEREEN. Definitely not. If you look at the Cal Data study where California looked at its investment in treatment, for every dollar they invested in treatment, they saved approximately $7. They found a $7 return on their investment in savings and health care cost, prison and other criminal justice costs. That is where you get the bang for your buck, as I said in my earlier statement. In addition, we have invested large amounts of Federal dollars on the research side. We are just beginning to see the fruits of that research.

We are understanding better what addiction is, so that we know exactly what it is we are treating; and the effects of treatment, not only in what is happening biologically in the brain, but what's happening behaviorally as we are trying to help the folks recover from addiction to become productive contributing citizens. So in that sense, treatment is a very good investment, despite some of the amorphous findings that we need to improve better how we measure outcomes, we need to improve better the self-reporting way we generate data.

Yes, there are ways that we can—we can study this better, and we can certainly improve treatment. But as it stands now, we are getting a very good return on what we put into treatment. So in that sense, I would not recommend cutting any dollars there.

Mr. BARRETT. Dr. Lillie-Blanton.

Ms. LILLIE-BLANTON. Well, in this report, I need to say we did not make recommendations on how to spend Federal dollars.

Mr. BARRETT. I understand that.

Ms. LILLIE-BLANTON. But I would say that our findings would show that treatment is beneficial both to the individual and society; even with an overstatement of the benefits. This would support our at least continuing to maintain the level of investment that we have now. The only point I differ a little bit is I think we really have to focus on improving the quality of our information about the effectiveness of treatment.

We have a responsibility as we spend Federal dollars to make sure that these dollars are being spent on programs that are effective.

Mr. BARRETT. So it's your complaint—or is your criticism more of the programs or that the information coming out of the programs is not accurate?

Ms. LILLIE-BLANTON. Until you have good information from the programs, you can't really know whether we're spending our dollars on the programs that make the most difference.

Mr. BARRETT. I understand.

Ms. LILLIE-BLANTON. So the two are linked, and that's why we've got to invest in improving the quality of the information that we have. I think Dr. Wish made a very convincing argument for why today is very different than 20, 30 years ago.

Mr. BARRETT. And in terms of the pie, as we look at the—where resources go—would you recommend cutting the percentage of the pie that goes to treatment?

Ms. LILLIE-BLANTON. I really think that's a policy issue.

Mr. BARRETT. I know. You're a citizen, for goodness sake.

Ms. LILLIE-BLANTON. As a citizen, I would say that we should invest more in treatment and less in our prisons.

Mr. BARRETT. Right. Dr. Satel.

Dr. SATEL. I would not cut any treatment money, but I would like to see a lot more go to the kinds of programs that the people in panel II are going to be talking about, the criminal justice-based programs; drug courts, in prison, in jail treatment. Those are very—those are going to be very promising because (a) they catch a lot of addicts. Most hard-core addicts have some contact with the criminal justice system.

I also think the program of coerced abstinence that the administration has funded is a very wise one and should be extended to both probation and parole. Coerced abstinence would be a regimented series of drug testing for those individuals, with those graduated sanctions that I mentioned before.

Also, I wouldn't mind seeing some more residential programs, you know, the kind where people stay for 18 months to 2 years. When people complete those programs, they actually have a very high success rate, but you have to complete it.

And my final point. I agree with what Dr. Blanton said, and also Dr. Wish, about the drug testing and wanting to get more accurate information; but you also have to, I think, realize you'll get a double bang for the buck here. Not only will you get better information, but the drug tests themselves, assuming the clinics, you know, respond to the data they get—if the drug tests are positive and that there are consequences for being positive, you'll get a clinical—presumably you'll get a clinical impact as well as a, you know, an information-enhancing result.

Mr. BARRETT. OK. Dr. Wish.

Mr. WISH. Thank you. I want to correct a possible misimpression here that the assessment of treatment outcome is so bleak. There are a lot of good studies that have used biological measures to assess treatment outcome. The problem is there are also a lot of large national studies that have not, and that is what should be changed. I also have to tell you that the Cal data study is one of the worst examples of this problem.

They basically brought people who had been in treatment into a room with an interviewer, and in one interview they said OK, how

much—I'm exaggerating a bit—but basically how much did you use drugs before you went to treatment and now how much are you using it now? And, you know, anyone who is being interviewed by someone who knows they are in treatment, they want to look good, it's a big social desirability.

Mr. BARRETT. Let me get back to my question. I know there's a lot of problems with self-reporting. My question is specifically, Do you think we should be cutting that percentage of the pie that goes to treatment?

Mr. WISH. Absolutely not. We are now moving toward focuses on the large illegal drug use problem in the adult offender population, but there are still people out here, every month I will hear someone, a probation officer who has someone who has a drug problem and they can't get them to treatment because there's not enough space for them.

In addition, in our research when we look at these adult offenders who are found to be almost walking drugstores, they're just pharmacologically overrun with drugs, you ask them when they began their drug use. It isn't at 20, it isn't at 25, it's back in the early teens. And we in this country miss a tremendous opportunity to stop the problem early by intervening with the youths who are coming through the criminal justice system.

And if you look at the statistics on testing kids at different ages who are coming to the criminal justice system, it goes up at a 45-degree angle where maybe 10 percent of the kids test positive for drugs at age 10, by the time they're 16 it's maybe 30, 40, 60 percent, like the adults.

Mr. BARRETT. Dr. Satel suggested that we should be putting more resources into the prisons; is that correct?

Dr. SATEL. Prison-based treatment.

Mr. BARRETT. Are you further refining that, saying in the juvenile justice system is where we should be doing that?

Mr. WISH. I think we need to hit them before they get to prison, that's sort of the last resource when it comes to juveniles. There's this whole group of kids coming in who are having problems, who are going back to the schools; and basically, for the most part, we don't assess them for drug use when they come into the system, and when they go back into the schools there's no further followup.

I would recommend that since these are the high-risk kids who are going to be the bigger problem of tomorrow, that we intervene with them when they go back to the schools, maybe do some drug testing, drug prevention, and prevent them from going on to becoming one of these adult drug-abusing offenders.

Mr. BARRETT. Mr. Soucek.

Mr. SOUCEK. No, I do not believe that we should be reducing treatment, because obviously I'm a treatment provider and treatment dollars support the services that we render.

I also would like to cite some examples. When we talk about success, when the chairman asked me about what is success, it depends upon how you define success. We have a prenatal program—and Ms. Foley is going to be talking about that tomorrow—that program was started in the early 1990's. It was primarily for women who had cocaine problems, but they also abused alcohol.

They also got into marijuana and other things, but primarily cocaine.

When we started that program, we started it with the notion that we would take women at any time during their pregnancy, which was a little bit different than other programs. They usually cut them off at the first 5½ months of their pregnancy, they would not admit them after that.

That program to date has produced, as a result of a drug-free environment, proper medical care and proper nutrition, over 500 babies that have been born drug free. Just the cost effectiveness of that one program alone has probably saved, in the course of those babies' lifetimes, maybe millions and billions of dollars to the State, city, and Federal level.

We also have an alternative to the incarceration program at Haymarket Center, and in that program, we can measure success by one measure: completion of treatment.

One of the presenters today said that there's a 1 in 5 or 1 in 4 completion-to-treatment rate. In that program for nonviolent, typically DUI, driving-under-the-influence offenders, who are multiple serious DUI offenders, they received more than one DUI, we have a 99-percent completion rate. Now, this is coerced treatment, but we are a voluntary program, which means that the courts ordered them into treatment. But if they walk out, we have no ability to keep them there by any force other than reporting to the courts.

Something happens to those people in treatment. During the course of treatment, they initially resist what we're doing. But by the end of treatment, many of them thank us for what they have done and return back to tell other people, future participants in that program, of their particular experiences.

I also just want to mention briefly, Haymarket started as a social setting detox center in the city of Chicago in 1975. It was a very controversial program. It was for skid row alcoholic males, and it was controversial because people thought that it would not provide the medical services necessary. We continued to do detoxification services at Haymarket and from its inception, Haymarket has been credited by the Chicago Police Department, by the Cook County Hospital, and by other mental health agencies as probably saving not only people's lives, but the lives of family members who have been put and placed in jeopardy as a result of somebody who is abusing or addicted to alcohol and substance abuse.

The detox center has been credited for the reduction in people coming in there with heat exhaustion. On a day like today, before 1975, people would be literally lying on the streets and dying and being taken into Cook County Hospital. Now they have a place to put them, and it's called Haymarket Center.

So, in our opinion, treatment does work. Success is something that still needs to be defined. I don't know that success is always a person just remaining drug free for the rest of their life. But cutting treatment dollars, in my opinion, would be disastrous.

Mr. BARRETT. OK. Dr. Satel, is that how you pronounce it?

Dr. SATEL. Yes.

Mr. BARRETT. You mentioned leverage, and tomorrow we're going to be having a hearing on the issue of cocaine moms and the use of criminal justice sanctions for children in need of protective serv-

ices, as they do in my State. I think anybody who looks at this issue at first says well, of course, you want the mother to get the treatment. Interestingly, we hear from some providers who argue that what you're doing is in effect providing disincentives for pregnant women to come into the medical field.

In the medical—I would like your comments on that.

Dr. SATEL. Yes, I would like to see their data on that. The data I've seen are from the South Carolina experience, and actually none of these—these were women who did not even keep—did not have any prenatal care at all, presented for the first time to the emergency room in some sort of life-threatening crisis, either hemorrhaging or pre-term labor.

In fact, when they were sent out again—because they hadn't, you know—they were patched up, so to speak, to finish the term of the pregnancy and then return to actually deliver—none of them kept their appointments with substance abuse. They were all referred to a treatment. Finally, they came back to have their babies, all were cocaine positive.

The point is that program there was started out of desperation, and the population that it addresses are those who frankly aren't very good at keeping their prenatal appointments to begin with. So I don't know how many you would lose if you instituted this, because of ones that it addresses, a policy like this addresses those who are so dysfunctional, they're not good at keeping their appointments to begin with.

Also, there was concern when the South Carolina experiment—not an experiment, the South Carolina program was in effect—that the women would not return to have the babies, and that's not true. They all returned. The rate of home birth in the county in Charleston did not increase. So there was no, you know, fugitive birth, so to speak. They all did return. And, actually, they all subsequently, they were—these were women who were, as you know, sent to—given the choice of treatment or jail, you know, the subsequent population of women that this goes to.

Mr. BARRETT. Do you know if there has been any analysis of a change in women seeking prenatal care, other than anecdotal?

Dr. SATEL. That's the only data I'm aware of. Do you know of any?

Ms. LILLIE-BLANTON. No. But let me just mention, I know of one source that I can suggest you follow up on, and I can also follow up on it and get it back to you. But I do want to mention that the one journal article that has been published on the South Carolina experience did look at birth rates in the county, but it did not look at whether or not women actually went outside the county into surrounding areas to give birth.

If you're going to do a study to make an assessment of the impact of that policy, you've got to look beyond just the county, to see if women are seeking care elsewhere. I know of one study that examined hospital policies regarding drug abusing pregnant women. It was dissertation research conducted at Johns Hopkins by Katherine Aculf, I can at least find out what data source was used and if she did any other work that would better help us know the impact on healthcare-seeking behavior. I'll find that and get that to you.

Mr. BARRETT. I would appreciate that.

Dr. SATEL. That's a good question.

Mr. BARRETT. Thank you. Mr. Chairman.

Mr. BARR [presiding]. Dr. Wish, if we could focus on an area that I've heard about in my district back in Georgia, and from some—particularly parents from other districts as well—and that is drug testing of students with parental consent. What would be your views on that? Is that something that you think would be worthwhile looking into, that schools can in fact drug-test students with parental consent?

Mr. WISH. You know, it's interesting. I've seen a number of news articles coming across my desk, indicating that different districts are changing and different States are changing the laws so that they can do that. As you know, the Supreme Court upheld drug testing of high school athletes in Oregon.

I come at it from a little different way. I think that I would not want to spend the money, the taxpayers' money, to look for the relatively infrequent hard drug use problem in the school population until——

Mr. BARR. What would you consider a hard drug use problem?

Mr. WISH. Cocaine, opiates don't show up in that age group.

Mr. BARR. Most parents, including myself, would consider any illicit drug use by our children to be fairly serious. I am not sure why it would hinge on the subjective interpretation of a hard drug usage.

Mr. WISH. I'm not saying it isn't serious. All I'm saying is that the primary problem that I would want to attack first is the drug use among the kids who have been arrested, because they're high risk. They're, for the most part, the kids that are are going to develop into your career criminal; and their drug use, if unchecked, will go on to the heroin and cocaine.

Mr. BARR. I'm just curious. I'm not necessarily disagreeing with you, but why wait until it's an extremely serious, perhaps irreparable problem? And similar to the theory behind drug testing in the workplace or in government offices, is there not something to be said for having a deterrent effect?

Mr. WISH. I think there is. There's quite a bit of evidence to support the deterrent effect of drug testing. And as you may know, parents already have the right to order—to purchase drug tests, so if they want to test their children, they can.

Mr. BARR. No thanks to the FDA on that. They were threatening criminal prosecutions of parents who tried to do that. And thank goodness, they backed off on that.

Mr. WISH. Right. I just—when I compare the immensity of the population in the juvenile justice population versus the student population where you have kids who are for the most part going to school and are doing OK, I would want to test in that high-risk population before I would spend the money.

Mr. BARR. Would it have to be an either/or? In other words, we see there's a problem certainly, as you've described, with students who use drugs, if not on a regular basis, at least more than one time experimentally. And we know the effect that that can have on other students certainly as unfortunate role models. We're already

attacking that problem to some extent. Maybe there ought to be more done to that.

But why would we have to take from the attack on that problem to institute a more comprehensive, longer term program and the important signal that it would send to tell students that as long as your parents consent, you are subject to drug testing at school, and so that the school administrators and teachers know that they have that as a stick, so to speak, and trying to keep students off of drugs so that they don't fall into that category that you're describing? Do you really see it as an either/or?

Mr. WISH. For the most part I've been talking about this for about 10 or 15 years and, generally, politically the question always goes back to the kid who is in school, when, you know, I see the problem as the reluctance to spend the money on the real high-risk population first. If that were taken care of, then I would say, OK, then go on and do the other, because it does tend to be an either or as far as I can see it. The focus is on the kids in school and not the juveniles.

Mr. BARR. But you don't have any problem with it as a concept, certainly?

Mr. WISH. By principle, no, I don't think so. But, however, one of the pitfalls in using drug testing is that people see it as the answer. What the drug testing does is open up the problem. So the question is, once you do the testing, what are you going to do with the kids who test positive? What is going to be put into place? Is it going to be a treatment response? Is it going to be a punitive response?

Mr. BARR. That's a very good point. I think we ought to keep that in mind in all aspects in the war against drugs. For example, the recent ad campaign, in my view, very, very good ads, and potentially a very worthwhile component of the war against drugs. One might have preferred that, you know, the administration would have done something before 5½ years, but certainly better late than never.

The value of any component really hinges on it being part of a comprehensive approach and there having followup. We can't just expect that if we throw a couple of billion dollars at some nice ads, it's going to solve the problem if we're doing nothing else with the other components of the drug problem or if we're not following up on that ad. I think that's a very good point with regard to testing.

Dr. Vereen, when do you anticipate seeing General McCaffrey next?

Dr. VEREEN. I will probably speak with him this afternoon.

Mr. BARR. Do me a favor, if you would, and give him my best remarks and thank him on behalf of myself and, I suspect, a lot of other members of this panel, if not all of them—certainly I just speak for myself. Thank him for his recent statements with regard to drug legalization and sort of dispelling this myth that some drug legalization proponents in this country are trying to build up.

I think his statements with regard to the Netherlands and the unfortunate and very tangible results of their legalization and pro-drug policies are not the panacea that some would have us think. It took a lot of courage to do that, and I compliment him for that. I wish you would pass that on to him.

Dr. VEREEN. OK.

Mr. BARR. Also, if you would, take him a message that we would hope and expect, certainly, that he would take a similar approach here in this country with regard to—there are three States in particular, I believe, on which ballots or in which ballots or referenda will be on the ballots this year: Florida, Colorado, and the District of Columbia. And if you would, please, I would appreciate your views on this and how this ties into the overall problem that we're talking about here; and is your office and the Director's office firmly committed to speaking out against these drug legalization efforts, in particular in these three States; and will ONDCP be proactively involved in making sure that that message is heard across this country and particularly in those three States before the issues actually appear on the ballot?

Dr. VEREEN. We are committed, and our commitment is very clear in our strategy. If I use that as a backdrop, we are relying on data, on important information. In fact, you have heard from this panel how important good data is, and General McCaffrey was using and looking for data to make meaningful comparisons between the United States and other countries. In the area of legalization, making harmful substances more accessible puts our children at risk.

Mr. BARR. At greater risk.

Dr. VEREEN. It's clear that it puts them at greater risk. It is so clear we have difficulty making it even more clear. That is why we rest our views on that data, that our children will be at greater risk. I do not think you can say anything more than that.

Mr. BARR. Are you aware of what specific steps or policy statements will be made between now and the November elections, particularly with regard to those three States in which drug legalization will be on the ballot?

Dr. VEREEN. Yes. At this point, we are working very hard to figure out how to approach that issue. In some of these States, the issues are somewhat different and the approaches on how these issues got on the ballot and how they are being pitched are also different. I think the responses to each of the States have to be taken individually. So I am not aware of how the responses to each of those States will vary at this point.

Mr. BARR. OK. Thank you, Dr. Vereen.

Dr. VEREEN. You are welcome.

Mr. BARR. Mr. Barrett, did you have any additional questions for this panel?

Mr. BARRETT. No.

Mr. BARR. Mr. Mica, if you would like to reassume the chair, and if you have additional questions?

Mr. MICA [presiding]. Thank you. Thank you for assuming the chair.

I would like to ask our panel, if I may, a couple more questions. First of all, today we have had the opportunity to discuss the pie, all of the money that drug abuse and drug misuse, illegal narcotics, cost this Nation. I think it's $16-plus billion. We spend $3 billion-plus on treatment.

I don't think there's anyone on this panel or anyone in the Congress that thinks we should spend less on drug treatment or any

other element in this effort to stem the drug problem in our Nation.

The question whether it's education, interdiction, enforcement or, today, treatment, is whether that is in fact effective and whether we're getting good results for the hard-earned taxpayer dollars that we're spending. I think you get a unanimous vote on doubling the treatment amount, or quadrupling it, if we can show hard information that the programs were successful.

In today's hearing we've heard in your report, which was released in March of this year, GAO says research shows treatment is effective but benefits may be overstated.

Again, from our own General Accounting Office, that much of the data is inconclusive, that we base some of our funding on a questionable testing or analysis program, not using really hard drug testing, but self-reporting in a program that relies on—I guess, 56 percent of the subjects in the program were on parole. I'm a little bit concerned about that, because if we had criminals doing self-reporting, I think that the amount of crime in this country would be dramatically reduced. And this is, as you had stated, Dr. Lillie-Blanton, a criminal or illegal activity in many instances, again using illegal narcotics.

So that really brings me to a question of what is successful. Where should we be putting money? Now, it's my understanding that the bulk of the Federal dollars go through HHS; is that correct?

Ms. LILLIE-BLANTON. Yes, about half.

Mr. MICA. Yes.

Ms. LILLIE-BLANTON. About half, about 56 percent.

Mr. MICA. About half. Do we have any measure of asking from the agency, or requiring that any programs that are funded by the agency, a success percentage? Is there any measure of success, any way to gauge if this money is directed to programs that are in fact successful? Dr. Lillie-Blanton.

Ms. LILLIE-BLANTON. Let me explain that of the money that's gone, that is spent by HHS, most of that is block grant funds to the States through the substance abuse treatment prevention and treatment block grant. In 1981, we changed the requirements for reporting, allowing States to be more flexible in how they use their dollars.

Mr. MICA. We've been loose with the requirements?

Ms. LILLIE-BLANTON. There is a tension between the flexibility we give States and the accountability that we require of States, because we're allowing them to spend their dollars on programs that they define as meeting the needs of their communities. We are now being a little more prescriptive in the information we are requesting of States in their block grant applications. But this is very new.

Mr. MICA. We might look at adopting some measure of success. And then also we've heard that some hard testing should be a component to really determine whether or not we're getting accurate results; is that correct?

Ms. LILLIE-BLANTON. Yes. That certainly could be a requirement that the Congress could place for receipt of block grant funds.

Mr. MICA. Now, there are other areas that spend a lot of money. I think the second biggest area is the VA. Do we have any way of measuring success in the VA programs?

Ms. LILLIE-BLANTON. Yes. And let me also explain that with the VA dollars, we are reporting are treatment dollars as well as funds for medical care. We cannot disaggregate the other kinds of medical care that persons with a substance abuse problem in the VA system obtain.

Mr. MICA. Are you asking, or do we ask, the agency for some measure of success or how those dollars are spent? Dr. Vereen, is your office into this at all?

Dr. VEREEN. Yes, we are. But in the case of the VA, one of the problems is that it is hard to disaggregate some of those numbers. In the general area of treatment, we have tried to provide some leadership by taking the goals that we established in the strategy and attaching to those goals specific performance measures so we know how close we are to achieving the goals of getting more folks into treatment.

We know that when we look at treatment models that try to engage people into treatment, keep them in treatment, and make sure they graduate from treatment, we are finding better ways to measure how that is actually done. Once we find a good way to do that, and some States exercise some leadership we try to take that information and feed it back to other States. So the U.S. Department of Health and Human Services is involved in assessing what these States are doing with their block grant funding.

Mr. MICA. We have passed a measure in the House, and it's pending in the Senate, we need the drug czar's support for it, to require a little bit more accountability, a little bit more definite return on the dollars invested from the VA programs. It's very important.

Dr. VEREEN. Yes.

Mr. MICA. The veterans' population has a problem in this area. It's very important, that we look at what programs are successful and support them. We need your cooperation to do this.

There are two areas where we spend a big amount of bucks. One we just discussed and the other area where we have sort of a captive audience is our prison population. We've talked about that a little bit today. Are most of our programs there testing based? Are we testing them in prison and then when they get out of prison, in probation programs? Do you know, Dr. Vereen?

Dr. VEREEN. Yes. A number of the studies do combine the self-report measures with biological measures. Urine testing is the best example of one that has been studied extensively. That's been the most studied.

Mr. MICA. There's no requirement that a Federal prisoner, in particular, who has had a drug problem or offense is required to come back for drug testing, is there, while on probation?

Dr. VEREEN. I am not aware of any requirements per se, but the most successful programs certainly employ those kinds of measures to supplement the other information they are getting so that they can monitor the situation. Monitoring progress is a very important part not only of the program that they are in, but because they need to feed back that information to the individual so that they

can apply the requisite sanction if they have fallen off the wagon, so to speak.

Mr. MICA. Well, again we have a captive audience. We heard Dr. Satel testify today that when you have leverage and then when you have strict accountability, you get results. Dr. Wish, I think is also familiar with a Vietnam study. Maybe you can tell us a little bit about that, and was that successful or what happened with that study?

Mr. WISH. That was a very different population of people that were basically followed up. A random sample of the Army enlisted men who were returning to the United States in 1971 from Vietnam were followed up in the early seventies, and that study showed very dramatic results, very different from what had ever been shown before in this country with regard to the costs of addiction.

Basically, almost all of the people who had become addicted in Vietnam to an opiate, when they came back to the United States were found to remit from dependence, with or without treatment. It's always been a question of why in this population was there such a remission from dependence, when in every study that had been done in the United States with people coming through treatment, there was a tremendous amount of relapse. No one really has the total answer to that.

It could be that the veterans learned the drug use in Vietnam and when they came home, they went back to their families and to their communities, and they weren't used to getting drugs there and they didn't have them as much available. It could also be that the type of person who went into Vietnam was very different from the type of people we're used to seeing in the big city treatment facilities, because as you recall, you couldn't be drafted if, for instance, you were a felony offender.

So the type of people that were going through the service at that time in Vietnam had—were more likely to be educated and to have jobs and have a different type of history than the people who we've studied traditionally in drug treatment outcome studies. So I'm not clear how to make the link to everything else.

Mr. MICA. Well, just as an example, just citing it today as another example. I think Dr. Satel had also referred to the need for increased residential programs which would also create a new environmental setting. Sometimes these programs are expensive. That was a little bit different illustration and example. But again, sometimes the treatment, maybe if it is more environmentally different, and sometimes those programs—also cost—may cost us more. But if they're more effective, again, I think we're looking today at what's effective. There's no price tag that we can't meet if we can find programs that are effective.

This leads me to my last question. We've talked about prisons, we've talked about veterans, we've talked about money through HHS and other programs. My opening comments dealt with the problems we're having with our young people in the dramatic rise of drug abuse, illegal narcotics, with our young people.

I'm wondering if there are any programs that we're looking at that we have hard evidence. We've heard a little bit about some State programs, we've heard about some faith-based programs. Are

there any really good programs coming on the horizon for our teens?

I think there was also testimony, Dr. Wish, I think you said get them early and we eliminate a lot of problems. But we're even finding with young people that have abused, that it's very difficult to find successful programs and to get a good rate of successful treatment.

My final question to all of you is: Do you have any ideas of how we can best direct our Federal dollars toward our teen and youth problem? Dr. Vereen.

Dr. VEREEN. Yes. I should first mention that the media campaign we launched nationally, a couple of weeks ago, is certainly one of the first steps. It is important to change the attitudes of young people before they even get close to drugs. We know that youth attitudes against drugs are linked to their actual use and to their sense of how dangerous drugs are. So, if they get the information about how dangerous drugs are, they are less likely to use them. Our goal is to delay the point at which they are tempted.

The media campaign is attached to something really important and that is the development or strengthening of communities against drugs; the development of community coalitions. All kids live in the context of a family and a community, and supporting those communities and supporting the values that go along with resisting drugs is very important.

As far as specific interventions, you are aware of drug courts. We are just beginning to evaluate the effectiveness of drug courts. They are very important in having an effect on those folks who are addicted and get into trouble with the criminal justice system. They do have a captive audience, as you put it. The early data suggests there is an excellent return for the dollar there.

Furthermore, juvenile drug courts are just starting to emerge. There are 37 at this point. The preliminary evidence suggests they are as successful, if not more successful, in curbing drug-taking behavior and criminal behavior in that younger set. We are awaiting anxiously more data to support those positive results.

Mr. MICA. Thank you. Dr. Lillie-Blanton.

Ms. LILLIE-BLANTON. Let me just say, that based on our review, services and research for adolescents was certainly a gap in the portfolio.

Mr. MICA. Services and research.

Ms. LILLIE-BLANTON. Research on drug treatment services for adolescents——

Mr. MICA. Something for adolescents' programs, something we should look at.

Ms. LILLIE-BLANTON. Yes, it was a gap in the portfolio of the Department of Health and Human Services. I would say that they have realized that and are making efforts to correct some of the imbalance. Some of the reason for the imbalance is that the rise in drug use among adolescents is a relatively new phenomenon. As such, it's not a problem that really was high on the policy agenda, but that's something that is very much changing.

One information source that will become available in 1999 is a followup study on the drug abuse treatment outcomes of about 3,000 adolescents in 30 programs in six cities. This will provide one

of the first objective sources of information on what works best for adolescents.

Mr. MICA. Is that also self-reporting?

Ms. LILLIE-BLANTON. It probably will be self-reported data but DATOS has also done a subsample of study participants in which they verify the self-report with some objective measures. It's conceivable that they will do that with the adolescent population as they did with the adult population. But I don't know for certain.

This will, at least, provide us beginning information about the effectiveness of adolescent treatment on a national basis, which then could be used to help direct Federal dollars. It's difficult to direct Federal dollars to new programs if you don't have some sense about what programs work best. So this will help.

From our review of the literature, it seems that family based therapy is being identified as the most promising approach. But even that approach has not shown itself consistently to be more effective than some of the other approaches that are being used.

Mr. MICA. Thank you. It would be good if we could get a little sampling of some hard testing data in the teen area, too.

Ms. LILLIE-BLANTON. Yes, I would agree.

Mr. MICA. We don't have a captive population, but we have a population. I think we could look at some measure of tests, drug tests that are done, and see what the results are and compare them to the self-reporting.

Dr. Vereen, just one thing on the ad program. I've supported that. I had a different measure before Congress, which was to increase the declining public service requirements—since the public owns the airwaves, and every year there are fewer and fewer PSA's on television—that we increase that requirement. I hope we will work on that, so it's just not taxpayers buying more TV money.

The other thing, too, that I hope you'll look at is the issue of using the media. If you talk to any political consultant or anyone that sells soap or dog food, they will tell you you need saturation to be effective, and you're talking, 2-, 3,000 television rating points. You're also talking about targeting audiences, young people and others.

Some of what I've seen so far is nice, but I'm not so sure it is effective. But I hope we're going to see some test areas where it's targeted, where it's saturation, where we also are measuring the results. I have seen some of the ads in the newspapers. They are great, but I don't see too many teens reading the Washington Times or the Post or some of these other publications. Those are some of our target groups. Just those comments.

Dr. Satel, anything in the teen area?

Dr. SATEL. Just two things. One is to emphasize the promise of the juvenile drug courts. And the other is also a call for, again, residential treatment, because what that focuses on—for adolescents as well—basically focuses on socialization. That's extremely important, but it's intensive. So that can be a very useful intervention as well.

Mr. MICA. Thank you. Dr. Wish.

Mr. WISH. If I may well deviate for 1 second, urine drug testing is so inexpensive, it's $10 to $20 to test for most of the drugs we're talking about. When you compare, to do one of these large studies

with an interview, it may cost anywhere from $300 up. And it's a very small amount. And it's very hard for me to understand why urine specimens are collected at all of these researches.

Mr. MICA. Government can usually find the more expensive way to do it.

Mr. WISH. Now, the second point is, I know we've all heard that advertisement "Pay now or pay later." I think that in terms of the way we approach the criminal justice system and drug use, we're more likely to pay later, and we don't want to pay now. I would recommend universal drug testing of juvenile detainees at admission and post-release, coupled with programs of intervention and prevention and treatment.

Mr. MICA. Thank you. Dr. Soucek.

Mr. SOUCEK. We at Haymarket do not do adolescent treatment. I had been involved with a program that did do adolescent treatment and it's a very difficult issue to address. We do believe that treatment does work; that, in fact, people coming into treatment may relapse, may deny their usage. But we also believe that seeds are planted. And there are literally in this country millions of people recovering that have many, many years of recovering sobriety, and cling to treatment programs and self-help groups, that I think are not being studied and not being questioned about, you know, how long they've been sober and clean and how productive they've become in terms of citizens of this country.

Mr. SOUCEK. As it relates to adolescents, I would like to mention that the problem that I saw when I was doing interventions with adolescents and their families was that many of the adolescents got some of their best highs right out of the home itself, from the medicine cabinet, from the liquor department.

In our society, we put limitations on alcohol purchases by adolescents, and yet, I don't know if this panel is aware of it, but the new hand washes that are on the market today contain about 90 percent ethyl alcohol, which is the kind you drink. Now a kid can walk into any drugstore, purchase a small bottle of that, mix it with some soda or something—or they are even flavored, as a matter of fact, there are some peppermint-smelling kinds of things—and can get a buzz that you would not believe. We are talking about 160-, 180-proof alcohol being mixed in there. And my experience with adolescents, when I was doing it back in the mid-eighties, was that kids knew this, they knew this about Nyquil, they knew this about cough syrups that were on the market, and would come in not only under the influence of marijuana, cocaine, but a lot of them would come in under the influence of prescription drugs, right out of mom and dad's medicine cabinets or from purchases they made at the drugstores of common cough syrups.

Mr. MICA. Well, I want to thank each of our panelists today for their testimony, for their participation, and for their willingness to help us find solutions to very difficult problems facing our country, and particularly, as we ended on the note of our young people.

We will have additional questions from other panelists and from myself and we will leave, without objection, the record open for an additional 10 days, so I will dismiss you at this time and thank you for your participation.

I would like to call our second panel today. Our second panel today starts with Mr. Bryan Hill, who is the president of the American Jail Association and warden of the Monroe County Pennsylvania Correctional Facility; Mr. Arthur Pratt is president of Life Effectiveness Training; Dr. Douglas Lipton is a senior research fellow with the National Development and Research Institute; and Dr. Faye Taxman is an associate research professor at the University of Maryland. I would like to welcome our second panelists members today.

As I informed our first panel, this is an investigative oversight subcommittee of the U.S. House of Representatives, and in that regard, we do swear in all of our witnesses, so if I could ask for you to stand, if you would, and raise your right hands.

[Witnesses sworn.]

Mr. MICA. The witnesses answered in the affirmative, and, again, I am pleased that we have your participation in this important subject of trying to find out what drug treatment programs are effective, trying to determine how we should best spend our Federal tax dollars, and where the emphasis of this Congress should be in supporting successful treatment programs.

Again, I mentioned to our other panelists that we will put lengthy statements in the record if you so desire, additional material upon request, but we ask you to try to limit your oral comments to the panel to 5 minutes. We will also reserve questions until all panelists have testified.

With that, again, I would like to welcome Mr. Bryan Hill, president of the American Jail Association, and he is also a warden at Monroe County Pennsylvania Correctional Facility. Welcome, Mr. Hill. You are recognized, sir.

STATEMENTS OF BRYAN HILL, PRESIDENT, AMERICAN JAIL ASSOCIATION, WARDEN, MONROE COUNTY CORRECTIONAL FACILITY; ARTHUR PRATT, PRESIDENT, LIFE EFFECTIVENESS TRAINING; DOUGLAS LIPTON, PH.D., SENIOR RESEARCH FELLOW, NATIONAL DEVELOPMENT & RESEARCH INSTITUTE; AND FAYE TAXMAN, PH.D., ASSOCIATE RESEARCH PROFESSOR, UNIVERSITY OF MARYLAND

Mr. HILL. Good afternoon. Thank you for the opportunity to testify. My testimony is a brief of my written testimony, and I ask that it be made a part of the record.

Mr. MICA. Without objection, and, also, all other additional statements of this panel will be made part of the record.

Mr. HILL. Thank you. The American Jail Association's main mission is to support the professionals who work in and operate America's jails. Jails are considered by many as not being fundamentally different from prisons. However, jails are characteristically set apart from prisons by their differences.

For instance, most jail professionals recognize that average daily population is not a true indicator of the length of time an average inmate spends in jail. The reality of jail population dynamics are such that a majority of inmates are released within a very short period of time, most of whom make bail or are released on their own recognizance. A still very large number of inmates remaining in custody will do so for weeks, months and even years. The use

of averages works well for prison populations, but are irrelevant in jail decisionmaking. Unfortunately, many in jail programmatic opportunities including substance abuse treatment are dismissed because of the reliance by the decisionmakers on using average length of stay as an indicator of the number of inmates who might be amenable to drug treatment in a jail setting.

Jails, for the most part, house inmates who are pretrial or serving sentences of less than 1 year. We however are finding, in addition to their less than 1-year inmates, jails are beginning to take on the responsibilities that traditionally had been left to prisons.

Jails offer an opportunity to address substance abuse upstream of the problem—an inmate who is incarcerated in prison, has been on the merry-go-round of continuously reoffending, being rearrested and being reincarcerated over and over again.

The question could be posed, where can we have the greatest effect: at the prison level, where an offender, now a felon, has most likely been in and out of jail a dozen or two times and has become part of the criminal culture; or at the jail level, when a first-time nonviolent offender hears the doors of the jail slam behind him for the first time?

Jails offer a unique opportunity for community linkage. This not only includes a continuation of treatment upon release, but the ability to partner with local agencies for the provision of education, treatment, vocation, industries, job and life skills—before, during, and after a period of incarceration.

The experiences of many jurisdictions throughout the country have resulted in a great deal of practical knowledge and proved some previously held assumptions with regard to drug treatment in jails. We now know that drug treatment is an effective vehicle for helping to prevent offenders from returning to chronic patterns of substance abuse and crime. We know that drug treatment does work if it is implemented properly. We know that in addition to the necessity of substance abuse treatment programs and jails, that a continuum of care in the community is essential. We know that the jail setting offers an opportunity for abstinence. We know that abstinence affords the inmates an opportunity to begin not only addressing their substance abuse problem, but their own physical, emotional, and spiritual deficits which they may be experiencing.

We know that communities benefit because treatment offers an opportunity to intervene in the inmate's cycle of dependency by providing detoxification, medical and psychological stabilization and so forth.

We know that success is accomplished through a commitment to follow participants for a reasonable period of time after the program participation has been completed.

Also important to a successful drug treatment program is ensuring that there is no availability of drugs in the correctional facility. In order to do this, a policy of zero tolerance must be adopted. We know that the more successful zero tolerance programs include drug testing that generally subjects inmates to frequent, random, and targeted drug testing.

Inmates who test positive for drugs must receive swift, fair, and appropriate sanctions. This demonstrates to the inmates involved

and others in the jail that the facility is serious in its efforts to be drug free.

Thank you for this opportunity to provide input to this subcommittee. We are missing the opportunity of a lifetime to make a positive impact on crime rates, arrest rates, and incarceration rates by ignoring the power of grass-roots community abilities and addressing the Nation's drug and alcohol problems.

We simply cannot wait until an offender has been accustomed to the criminal justice system and, in fact, has become part of that culture. Jails with the proper resources and in the hands of jail professionals and community agencies represent our best chance at tackling the substance abuse problem upstream. Thank you.

[The prepared statement of Mr. Hill follows:]

PREPARED STATEMENT FOR SUBCOMMITTEE ON NATIONAL SECURITY, INTERNATIONAL AFFAIRS, AND CRIMINAL JUSTICE

DRUG TREATMENT, DRUG TESTING, AND THE CRIMINAL JUSTICE SYSTEM

BY BRYAN L. HILL, CJM

Good Morning, My name is Bryan Hill, President of the American Jail Association and Warden of the Monroe County Correctional Facility in Stroudsburg, Pennsylvania. I come here today on behalf of the over 3,300 jails in America.

The American Jail Association's main mission is to support the professionals who work in and operate America's jails. The jail profession is a specialty within the broad scope of corrections.

Most often, jails are considered as being not fundamentally different from prisons. But, jails, or local detention and correctional facilities, are characteristically set apart from prisons by their differences. Despite this fact, jail statistics are often interpreted as if they were prisons. Michael O'Toole, now the retired Chief of the National Institute of Corrections Jail Division, famous for his statement that "jails and prisons are similar in unimportant ways," illustrated many of those differences in an article written for *American Jails* magazine in 1997. He pointed out in a Bureau of Justice Statistics (BJS) Bulletin, that the average daily prison population (ADP) was about one million.

The total prison admissions for that year were about five hundred thousand. The ADP of the nation's jails was about five hundred thousand. But, in that year, it was estimated that there were between 10 and 13 million admissions to jails. It takes about two years to turn over the prison population, while the jail population turns over 20 to 25 times each year.

Perhaps the most misunderstood statistic is that of average length of stay. The average length of stay is calculated by dividing the total bed days per year by the total admissions per year which assumes to indicate the average length of stay. Most jail professionals recognize that this is not a true indicator of the length of time the average inmate spends in jail.

The reality of jail population dynamics are such that a majority of inmates are released within a very short period of time, most of whom make bail or are released on their own recognizance. The still very large number of inmates remaining in custody, will do so for weeks, months, even years. The use of averages work well for prison populations, but are irrelevant to jail decision-making.

Unfortunately, many in-jail programmatic opportunities, including substance abuse treatment, are dismissed because of the reliance by decision-makers on using the average length of stay as an indicator of the number of inmates who might be amenable to drug

treatment in the jail setting. The conventional wisdom is that prisons hold persons convicted of a felony and sentenced to more than one year. Jails, for the most part, house inmates who are pretrial or serving sentences of less than one year. We are, however, finding that in addition to their less-than-a-year inmates, jails are beginning to take on the responsibilities that traditionally have been left to prisons. For example, jails in Pennsylvania can house sentenced prisoners for up to a day less than five years. Kentucky jails recently signed an agreement with the Kentucky State Department of Corrections to house Class D felons. It is not unheard of that many of the larger metropolitan jails such as Los Angeles County, CA, Cook County, Chicago, IL, and New York City, NY, can house pretrial detainees for literally years. Many jails are housing convicted felons that belong to the state because of crowding at the state prisons. Simply put, there are a great number of inmates who spend sufficient time in jails to benefit from substance abuse treatment programming.

Jails offer an exceptional opportunity for successful drug treatment. Jails are located within the community. The people that work in jails are community members and the majority of inmates incarcerated in them are also members of that same community. Jails offer a better opportunity for a continuum of care when they are released back into their respective communities. Those incarcerated in our jails and prisons today, especially in our jails, **will** be

returned to our communities. We have a choice to have them return in the same, better, or worse condition than when they first entered.

Jails offer an opportunity to address substance abuse "up stream" of the problem. An inmate who is incarcerated in a prison has most likely been on the merry-go-round of continuously re-offending, being re-arrested, and being re-incarcerated over and over again. To not provide resources for substance abuse treatment at the local jail level and to not afford jail inmates the opportunity to participate in a drug treatment program will ensure that they will receive a prison sentence.

The question could be posed, where can we have the greatest affect? At the prison level where an offender, now a felon, has most likely been in and out of jail a dozen or two times, and has become a part of the criminal culture? Or, at the jail level, when the first-time, nonviolent offender hears the doors of the jail slam behind him for the first time?

Jails offer a unique opportunity for community linkage. This not only includes a continuation of drug treatment upon release, but the ability to partner with local agencies for the provision of education, treatment, vocation, industries, job/life skills, etc. before, during, and after a period of incarceration. Communities

and offenders would be better served by not only addressing an offender's substance abuse problems, but also the rest of his or her issues.

Estimates have suggested that as many as 60 percent of inmates used drugs on a regular basis prior to their incarceration. Recognizing that this problem must be addressed and that the local jail is a good place to start, the American Jail Association obtained a grant to fund model jail-based drug treatment programs. This grant was awarded by the U.S. Department of Justice, Bureau of Justice Assistance to conduct this project titled, "Drug Treatment in the Jail Setting: A National Demonstration Program."

Under this grant, monies were awarded to Hillsborough County, Tampa, Florida; Pima County, Tucson, Arizona; and Cook County, Chicago, Illinois to establish model drug treatment programs in their jails.

The experience of these jurisdictions, and others throughout the country, have resulted in a great deal of practical knowledge and proved some previously held assumptions with regard to drug treatment in jails. We now know that drug treatment is an effective vehicle for helping to prevent offenders from returning to chronic patterns of substance abuse and crime. We know that drug treatment does work if it is implemented properly. We know

that in addition to the necessity of substance abuse treatment programs in jails, a continuum of care in the community is essential.

We found that, among jail inmates, fewer than one third of those referred for treatment have received treatment in the community in the past. The majority of the group is indigent or without private insurance to cover the cost of treatment. We know that they face serious environmental risk factors upon their release from jail, such as a lack of employment and employability, a lack of education, housing and transportation problems, insufficient basic life skills, estrangement from family members, and the exposure to the same people and environment which help fuel the reintroduction of illicit substances in their post-incarceration lives. We know that substance abuse treatment in jails offers the best opportunity to reduce the high rate of recidivism and to slow the revolving door cycle through the criminal justice system. We know that the absence of in-jail treatment programs and linkages to community treatment agencies following release from jail, means that the vast majority of serious substance abusers will return to the streets without gaining the skills necessary to prevent a return to substance abuse and criminality.

We know that the jail setting offers an opportunity for abstinence. We know that abstinence affords inmates the

opportunity to begin not only addressing their substance abuse problems, but their other physical, emotional, and spiritual deficits which they may be experiencing. We know that the successful reintegration of offenders into main stream society depends on a holistic approach. We know that an opportune time for intervention in the substance abuser's lifestyle can occur within the jail. A jail is the first stop in the criminal justice system for a community's more serious substance abusers. The jail offers a controlled environment, where medical and psychological stabilization occurs and life's basics are provided. We know that inmates have time to focus on treatment issues and that inmates are more amendable to treatment, even though it may only be due to their belief that it may make a more favorable impression on the court or other authorities.

We now know that successful drug treatment programs require a continuum of treatment in the community following release. This community linkage includes case management re-entry treatment planning services with appropriate community treatment providers, prior to release. We know that inmates benefit from in-jail programs, because it affords them the opportunity to make a difference in their own lives and that of their families. At the same time, we also know that in-jail programs benefit the jails themselves, by reducing inmate idleness which makes for a more secure and safer institutional environment. We know that communities benefit, because treatment offers an opportunity to

intervene in the inmate's cycle of dependency by providing detoxification, medical and psychological stabilization, etc. It allows inmates to consider new clean, sober, and crime-free goals. The community further benefits by reducing the rate of recidivism following release into community treatment. Finally, those who do recidivate show a tendency towards longer noncriminal periods and less severe offenses, rather than the expected pattern of escalating severity.

This last point is especially important in determining what success is. In other words, what defines a successful treatment program? I think that most would agree that programs which result in persons becoming substance- and crime-free, as well as becoming contributors to society as opposed to takers, would consider this the ultimate success. However, most ultimate successes are achieved one little success at a time. In striving for the end, the means must be deemed invaluable to the equation and thus, successes in and of themselves. Many substance abusers who go through treatment <u>will</u> relapse -- This does not mean that the treatment program did not succeed. If jail days have been reduced or if criminality has been even temporarily avoided, we have achieved some measure of success.

In considering the issue of success, there must be a vehicle in place to help determine what is, and is not, being achieved. It doesn't matter how great or inadequate a program is if no one knows

whether or not the program is succeeding or failing. Another indispensable component to any program is the objective, unbiased, collection and analysis of empirical data that will serve to validate success and/or failure. I would add that this can only be accomplished through a commitment to follow participants for a reasonable period of time after their program participation has been completed.

Also important to a successful drug treatment program is ensuring that there is no availability of drugs in the correctional facility. In order to do this, a policy, similar to the military's zero tolerance policy, must be adopted. The more successful zero tolerance programs include drug testing. Generally, inmates in jails that practice zero tolerance are subject to frequent, random, and targeted drug testing; frequently enough that inmates have an expectation of consistency in the application of drug tests. They are done randomly to ensure that there is no real or perceived predictability in the pattern of drug testing. Finally, inmates who are suspected of drug use are targeted for drug testing. Properly trained professional correctional personnel are taught to observe inmate behaviors in order to point out those who should be targeted for drug testing.

Inmates who test positive for drugs must receive swift, fair, and appropriate sanctioning. This demonstrates to the inmates

involved, and others in the jail, that the facility is serious in its efforts to be drug free.

Along with the drug testing program, efforts naturally must also center on keeping drugs and drug paraphernalia outside of the secure perimeter of the facility.

Thank you for this opportunity to provide input to this subcommittee. We are missing the opportunity of a lifetime to make positive impacts on crime rates, arrest rates, and incarceration rates by ignoring the power of grass roots, community abilities at addressing the nation's drug and alcohol problem, in favor of waiting until an offender has become accustomed to the criminal justice system and in fact, has become part of that culture. Jails, with the proper resources and in the hands of jail professionals and community agencies, represent our best chance at tackling the substance abuse problem "up stream".

Mr. BARR [presiding]. Thank you, Mr. Hill.

Mr. Pratt, if you would please proceed to summarize your testimony, and I would remind you, again, that all the witnesses' full statements, whether they read them in their entirety or not, will be included in the record.

Mr. PRATT. Yes. I have included with my remarks a summary of five studies of drug alcohol treatment programs in county jails throughout the country, and you have that evidence on hand. And my remarks have a lot to do with that because we have chosen a specific goal. That goal was what was the results 2 years after treatment of the 90-day treatment programs in county jails. I want to tell you about studies that give strong evidence that drug alcohol treatment greatly reduces recidivism in county jails.

In 1981, a $30,000 study by Dr. Brian Vargus of our substance abuse program in the Marion County Jail in Indianapolis shows 47 percent of the inmates treated did not return to jail 3 to 5 years after treatment. I will mention that this was not a self-reported program. Dr. Vargus sent out Indiana University students to call on these people and their families and substantiate what had happened to them.

A control group of the same sort of addicted inmates not treated showed 74 percent had returned to jail. This is a 27-percent reduction in arrests due to treatment. In 1997, a study of the same program in Indianapolis showed 66 percent reduction in recidivism 2 years after treatment.

We have submitted to you a summary of four other studies of 90-day treatment programs in Portland, OR; Montgomery County, MD; Chicago; and Alexandria, VA, done largely by Ph.D.s comparing the persons treated with control groups of not treated persons and showing an average of a 54-percent reduction in recidivism 2 years after treatment.

Since these are repeat offenders arrested 3 to 12 times in the last few years, these statistics reflect a really massive reduction in arrests. For example, in Indianapolis, we treated Bill P. in 1978, he had already been arrested 53 times for drunkenness offenses. Since treatment, he has been sober and never arrested again. He has a good job, a wife, and two children. He could have been arrested another 53 more times without treatment.

I will also mention, George P, who was treated in 1979. He is now sober for 19 years. He has been a professor at Indiana University and is a Methodist minister.

Let's consider financial savings. Of the 183 persons studied last year in Indianapolis, 66 percent, or 120, have not been rearrested since their treatment in 1995, so we saved 120 arrests in that period of time. At $6,000 an arrest, and that includes court costs, 90 days confinement and probation, we saved $720,000 on arrests in 1 year at the cost of $43,000 for our treatment program, which was largely done by part-time persons and volunteers. The Portland study showed a savings of $760,000.

If drug alcohol treatment had been in the 2,000 major county jails in the country at this time, the savings and consequent reductions in crime would have been enormous.

Why is such treatment in county jails so effective? First, because of the courts mandating treatment for 90 days and following up for

at least a year, they have clients long enough to get them away from their compulsive habits and drug gangs, giving them an opportunity to form new habits and make new friends. Followup must include random drug testing.

Now, it's completely true that if you ask persons what drugs they have been on, if you try to have interviews with persons, many of them are very afraid of telling you that they have been on drugs because they will be indicting themselves. So random drops are very important in really studying this. But they are even more important in respect to the recovery of the individual because, as Dr. Satel had said, this is a crisis of the will in addiction, and when the will is reinforced by the courts who are saying, in effect, yes, you must have this, and you must have random drug testing, it reinforces the person's ability to stay sober. It is an instrument of treatment, not simply an instrument of study. So the funding, the 45 million that the Government is putting into drug testing is very important in the success of treatment.

Followup must include random drug testing. This pressure serves as a fence against drugs and alcohol, so the use of mandating power is at the heart of our success in county jails.

The private field of treatment, hospitals and clinics, frequently do not have the insurance funds to keep addicts in treatment 90 days, nor the legal power to mandate drug testing after treatment, and therefore could hardly be anticipated to achieve the results of jail and prison programs. We advocate a study of comparative effectiveness of mandatory versus nonmandatory programs.

Second, in the county jails we get them when they are young, often, 17 years old, and can help to redirect them to education, jobs, and better family relationships before they go to State prisons. I have had them at 13 years old. I have done groups with 13 year olds. Their response is excellent.

Senator Lugar's bill, S. 1876, and Representative Burton's bill, H.R. 4039, currently in the Senate and House, mandate jail-based substance abuse treatment for a minimum of 90 days, with 1 year after clear. They appropriate no new funding, but mandate 10 percent of the funding for drug alcohol treatment in State prisons to go to the county jails, a minimal expense to start a dynamic initiative against crime. And we find that at least half of our persons are involved in other kinds of crimes as well as drugs and alcohol, stealing, prostitution.

It is hard to imagine the effect that starting a drug alcohol treatment has on the morale of the enforcers of the criminal justice system at the local level. Imagine how police feel, locking up the same prisoners time after time; 85 percent of the 13 million persons sent yearly to the county jails are recidivists on drug, alcohol offenses.

When we established drug alcohol treatment in the Indianapolis jail in 1969, within a few years we also had a GED program, case workers, job placement, a work relief center and then a followup home detention program. We had taken the initiative against crime.

In Monticello, IN, when I trained the sheriff's department and drug alcohol treatment——

Mr. BARR. Excuse me. Mr. Pratt, if I could very respectfully urge you to sort of move forward fairly quickly, so we can give the other

panelists a chance to present their important points and then leave sufficient time for questions.

Mr. PRATT. I am just about done. Thank you.

Mr. Ernie Turner soon had Monticello's sheriff's department clearing White County of marijuana. They are really waging a war on drugs. We must, I repeat must, give the county jail sheriff's departments the power to take the initiative against drugs.

Talk about taking the initiative to restore positive morality in America, we are doing it. In treatment, we role play out family conflicts and encourage fathers to make the decisions to support their kids, boyfriends to marry their live-in girlfriends, and married couples not to divorce. We encourage forgiveness of self and others. One fourth of our clients get their GED's. We ask our clients to choose their own way back from addiction, whether it be AA, Narcotics Anonymous, church, rational recovery, or their own programs. We bond easily with our clients because we really listen to them and are willing to admit our own faults and addictions. We also confront them with their faults and addictions.

In short, we are the spearhead of sort of a spiritual movement that brings hope for a second chance to many young men and women who never had a first chance. For the sake of God and the common man, please support Senator Lugar and Representative Burton's legislation. The American Jail Association, the National Council on Alcoholism and the National Association of Counties, who know the catastrophe of addiction, are supporting these bills as well.

[The prepared statement of Mr. Pratt follows:]

A Summary of the Results of

Substance-Abuse Treatment Programs in Five County Jails,

Studying Recidivism Two or More Years After Treatment

Introduction. This summarizes the results of 90-day Drug/Alcohol Treatment Programs in Five County Jails, Indianapolis, Chicago, Montgomery County, Md., Portland, Oregon and Arlington, Virginia, at least two years after treatment. Studies include comparison groups of arrested persons who were not treated bud had similar arrest, age, sex and race with those treated. Chicago, Montgomery County and Portland showed an average 49% reduction in recidivism; Arlington, 59%; Indianapolis, 66%. The Indianapolis Program (with the largest cut in recidivism) saved Marion County $720,000 in reduced arrests at a cost of $43,000 for treatment in the year 1997 alone. These programs were chosen because they were documented by research and were of high quality of treatment.

1. In 1978, Dr. Brian Vargus commenced a two-year study of clients treated in the Marion County Jail Program in Indianapolis.[1] Dr. Vargus found that, three to five years after treatment, 20% of the clients had abstained completely and 40% had sufficiently altered their abuse patterns so as not to have been re-arrested. He determined that, of the clients treated, 47% had not been re-arrested. He measured a control group of offenders (who were similar in arrest charges, age, gender and race) but had not been treated and found that 74% had been arrested. The program had reduced recidivism by 27%. He concluded that the psychotherapeutic treatment provided "had all the indications of being highly beneficial and successful." This encouraged us to study substance abuse treatment programs in other county jails.

2. A residential drug treatment program called Impact, the Integrated Multiphasic Program of Assessment and Comprehensive Treatment,[2] located in the Cook County Jail in Chicago, began accepting inmates in February

of 1991. Out of the 453 inmates who were in the program, those who left it within the first month were re-arrested, on average, within 99 days of release, compared to an average of 178 days following release for those inmates who stayed in the program at least three, but not fewer than five, months. A 51% reduction of recidivism was achieved. The rate of re-arrests decreased with the length of stay in Impact.

Recidivism in this study was compared with three control groups which were constituted on the basis of how long each group had been in treatment. The study of this program states, "The overall recidivism rate was 51%; that is, apparently one half of the Impact Clients were re-arrested during the follow-up period...About 69% of those within the 1 to 30-day group compared with 55% in the 31 to 90-day group, 41% in the 91 to 150-day group, and 45% in the 151 and more-day group." The 31 to 90-day group is the treatment time comparable with the time of the other three jail programs studied in these papers.

3. In Maryland, a 24-month follow-up study was conducted of a jail treatment program funded by the Center for Substance Abuse Treatment.[3] The study consisted of 296 offenders participating in the Jail Addiction Services program and a statistically matched comparison group of 232 offenders. The jail program consisted of ten weeks of an intensive treatment program in the Montgomery County Detention Center. Offenders participated in a modified therapeutic community with assigned correctional officers and treatment staff from the local health department. The evaluation found that 38.5% of the JAS participants were re-arrested within 24 months compared to 48.7% of the comparison group. As shown here, participation in jail treatment reduced the probability of recidivism by 25 per cent and participation in jail and community treatment reduces the probability of rearrest by 50% for the average offender.

4. In Portland, Oregon, an evaluation of an in-jail intervention program and a comparison group[4] showed that females in the program group had 44% fewer subsequent arrests than their compsrison group counterparts. Males in the program's group had 27% fewer subsequent arrests than their comparison group counterparts. Males in the program had 23% fewer subsequent serious felonies (Class A and B) arrests than their comparison group counterparts.

This would result in an estimated savings of about $713,888 for the jail alone (based on an average LOS of 17 days and an average of convictions of 47 days and a cost of $90/day for jail bed space).

Meanwhile, in Marion County (Indianapolis, Indiana), Community Corrections had added to their Substance-Abuse Program a GED Program, Casework and a Work-Release Center. A second study made two years after the 90-day treatment program revealed that 66% of the 183 clients studied had not been rearrested.[5] This removed 120 addicts from the prison system. If the average cost of arrest per person is $6,000, this then saved the County $720,000 in rearrest. Since it might be projected that these recidivist clients, already arrested 3 to 12 times, might have an average of 5 future arrests, the savings would be much greater. Also, 120 tax-consuming clients might have become tax-paying citizens.

5. A study by the Alexandria Detention Center of 100 addictive clients treated for 90 days in the years 1993 through 1996 in their Sober Living Unit showed 59% not being rearrested two years later against a group of inmates not treated, matched not in offenses but age and sex only. The rearrest rate for those not treated was 44% but many of these inmates were sent to other prisons (where they couldn't have been rearrested).[6]

In 1990, the American Jail Association undertook the initiative to treat addiction in the jails. They collaborated with researchers Peters and May make a survey of addiction treatment in County jails.[7] The survey

showed that more than 750 of the 1,700 jails had no form of treatment whatsoever.

After the Federal Government's withdrawal from treatment in the mid 80's, the tremendous pressure of drugs/alcohol in the late 80's began to force prisons and jails to undertake addiction treatment themselves. The success of six months' to a year's treatment by Therapeutic Communities (TC's) in the State and Federal prisons showed that drug addiction could be curtailed, if not cured, is a breakthrough in medicine.

In California penal institutions, 120,000 addicted inmates were treated in 1991-92. In its CALDATA study, Chicago University's National Opinion Center tabulated the results of the treatment[8] and found that a savings to California of 1½ billion dollars derived from the reduction of recidivism. Inmates who were formerly wards of the State had become tax-paying citizens.

The Rand Corporation's numerous studies of drug/alcohol treatment in penal institutions stated that, for every dollar spent for treatment, seven dollars would be saved by the reduction of recidivism and ancillary savings in costs of courts, police, jailing and probation.

In 1994, Representative Charles Schumer, inspired by the studies of Dr. Douglas Lipton,[9] pushed through Congress a mandatory addiction treatment in states and "locals" (jails). The "Residential Treatment for Addictions for State Prisoners" bill authorized over $200 million for a five-year period. In practice, most of this funding went to State penal institutions rather than to the County jails, through which passed, in 1996, some 13 million prisoners, of whom 75 to 80% were estimated to have been arrested for drug/alcohol-related offenses. The increased use of alcohol, cocaine, heroin and marijuana were the principal culprits, resulting in drug-related activities costing the Counties more than forty billion dollars.

The national recidivism rate in county jails, according to the Department of Justice, is 25%. All the above programs show recidivism cuts of about 50%. If the mean recidivism rate in counties is 25%, this

shows a very consistent reduction of 25% of drug/alcohol clients treated in county jails. Why 25%? The question needs study, but I think that these 25 percenters were at least subconsciously "ready" for a more purposeful life.

The reduction of recidivism is 5 to 7% more successful when there is adequate aftercare. Examples of such aftercare are found in Cleveland and Tucson where Probation Departments use consistent periodic urine tests for up to 24 months of Probation. This helps to keep addicts sober long enough for them to adjust to a drug-free life and to make new friends, persons unlike their former drinking and/or drug-using cronies.

If universal substance-abuse treatment were achieved in the county jails, an estimated two million persons would be treated over a three-year period at a savings of ten million arrests. No wonder that General McCafferty, Director of the Office of National Drug Policy Control, urged that a major role be given to treatment in the war on drugs.

The County Jails must play a central part in this treatment role, for it is mainly in the County Jails that the incipient alcoholics and drug addicts first enter the correctional system. Should we not deal with them at their first incarceration and thus greatly reduce the number being sent on to the State and Federal Penetentiaries?

References

1. Vargus, Brian S., Indiana University-Purdue University at Indianapolis, Indiana, "Lock 'Em Up": A Study of Legal Processes and Impacts on Public Intoxication Arrestees, 1978.

2. Swartz, J. A., Lurigio, A. J. and Slomka, S. A.: The Impact of IMPACT: An Assessment of the Effectiveness of a Jail-Based Treatment Program, 1996. Crime and Delinquency Col. 31 No. 4 TASC.

3. Taxman, Faye S. and Spinner, David L., 1997. "Jail Addiction Services Demonstration Project in Montgomery County, Maryland: Jail and Community-Based Substance-Abuse Treatment Program Model."

4. Finigan, Michael. Northwest Professional Consortium. "Portland Target Cities In-Jail Intervention Program." 1997.

5. Bid, Charles, "Jail Component Recidivism Statistical Study." 1997. Reported to Community Corrections Advisory Board, Indianapolis, Indiana.

6. Study Results, "Comparison of Rearrest Data for Individuals Incarcerated in the Alexandria Detention Center who Completed In-House Sober Living Unit Program Versus Those who Did Not."

7. Peters, R. H., Dept. of Law and Mental Health, University of South Florida, Tampa, and May II, Robert, American Jail Association, Hagerstown, Md.: "Drug Treatment Services in Jails," (1990 (?)

8. CALDATA, University of Notre Dame, Public Opinion Laboratory, 1994.

9. Lipton, Douglas S., National Development and Research Institutes, Inc., NYC. "Drug Abuse Treatment in Jails: An Opportunity for Intervention," 1997.

Arthur Pratt, President
Life Effectiveness Training
520 E. 12th Street
Indianapolis, Indiana 46202
(317) 262-0683

Mr. BARR. Thank you, Mr. Pratt.

Dr. Lipton.

Mr. LIPTON. Thank you for inviting me to testify about correctional treatment that works, and I am enthused about this. I hope you catch some of the optimism that I feel.

Addiction treatment is obviously a critical component of the Nation's war on drugs and the incarceration of persons who were found guilty of various crimes who are also chronic drug users presents a propitious opportunity for treatment. It is propitious because these persons would be very unlikely to seek treatment on their own and, without treatment, they are extremely likely to continue their drug use in their criminal careers after release. Now we have, I am pleased to say, an effective series of technologies to treat them while they are in custody and to alter their lifestyles.

I feel genuinely optimistic regarding our ability to effectively treat people who are normally deemed by conventional wisdom to be irredeemable or very high risk, namely the chronic heroin and cocaine users with extensive predatory criminal histories that we all fear.

The high-rate addict offenders, such as these commit 40 to 60 robberies a year, 70 to 100 burglaries a year, more than 4,000 drug transactions a year, and we have reliable evidence from—and I will cite the studies to you that have substantiated a consistent reduction in recidivism after treatment, during incarceration, plus aftercare. This reduction has been, remarkably in the field of social science, very consistent across these five studies, in the range of about 25 percent between those treated and those in comparison groups. That is a difference like 75 percent success versus 50 percent success for those who have no treatment.

This is a substantial and tangible improvement in their behavior and consequently for quality of life. And I could describe to you, it is all in my remarks, about the specific findings in these studies. But I want to first make it very clear that as a researcher, I have been involved in this process since 1963. I am a professional skeptic. I was a contributor, perhaps, to the most important document, "The Effectiveness of Correctional Treatment," which came out in 1975, as the senior author of that document, which for whatever damnation you may throw at me, said that relatively little works. So I come from a standpoint of examining the data objectively and carefully, and here I stand, saying to you that I see successful outcomes. I see successful outcomes for correctional programs, which has been sustained over time and across projects, with groups of offenders who are otherwise highly likely to relapse to drugs and return to crime. It makes me sit up, at least, and certainly take notice and to report to you these results which have now been remarkably substantiated in study after study with differing populations. I convey to you my conviction that prison-based treatment for drug offenders works.

The studies that I have been referring to, the Staying Out Project, the Cornerstone Project in Oregon—Staying Out is in New York, Amity Donovan in California, the New Vision Project in Texas and the Key Crest Program in Delaware. Research demonstrates that these prison-based therapeutic communities that in-

clude aftercare programs have been markedly successful with drug-abusing offenders.

I also want to share with you in this very brief period some preliminary findings from a 4-year study we have just completed. The study of the Correctional Drug Abuse Treatment Evaluation Project, or CDATE, began in 1994 with funding from the National Institute on Drug Abuse. It is a comprehensive, detailed review of the evaluation research on the effectiveness of criminal-justice-based intervention programs for offenders in any form of custody. It is a meta-analysis of all published and unpublished research gathered from 1968 until 1997. We pulled together over 10,000 documents. There are 1,600 studies in this data base that I will be reporting very briefly to you, and it is just 30 years since the closeout of those studies that we did in the first book I referred to earlier, "The Effectiveness of Correctional Treatment."

We have sought out all credible evaluations, adult and juvenile, drug abusing and nondrug abusing alike, and examined them with the intention of informing policy and practice in the most meaningful way. Now, without going into detail about each of the program's findings, let me just assure you that the results are clear, robust, and consistent over time. The results, for example, with untreated controls, with reincarceration being the outcome variable in the experiments we did in Amity and Donovan Prison in California, the untreated controls did about the same, 50–50; 50 percent reincarcerated, 50 percent not reincarcerated.

With the therapeutic community and aftercare, the success rate was 91.8 percent after 1 year following parole as of mid-1995. That is 91.8 percent success. And reincarceration 2 years following parole was 86 percent success for that same group, as compared to only 32 percent success for the controls.

The similar percentages have been achieved in all of these, and please note that I said plus aftercare. One of the strategic elements in treatment is not just ending the treatment at the gate of the prison, but continuing in the community for at least 1 year, perhaps as much as 18 months. These individuals who have been through these programs, chronic heroin and cocaine users, for the most part, and indeed, in Donovan, about 15 percent were there for murder or very, very serious assault offenses, there were about 40 percent who had some kind of violent offense. So here we have an approach which not only works with drug abuse but also with violent offenders.

Now, we are talking about an appropriate intervention used and applied over a sufficient duration, and with that sufficient duration and adequate treatment continued with aftercare, three out of four are going to succeed, reenter the community, and subsequently lead a socially acceptable life.

Now, the study CDATE, which has been pulling together all of this other research, we have got 27 studies of TC's, and there is a consistent—now this is with all TC's from all over the world that have been researched carefully, and we have carefully looked at the research methods to exclude those studies which are flawed, and we conclude an average effect size of 17 percent for TC's across all TC's, English TC's, German TC's, as well as American TC's.

Now, let me just contrast that with correctional boot camps. We have looked at 107 studies of incarceration and punishment programs. The overall mean effect size for those kinds of programs is zero. That means that you just might as well not do it. I mean, it has the same results as no treatment. What happens when we focus on boot camps? We have 24 programs that are boot camps, called boot camps, and the average effect size is 0.04, which is equivalent to a 4-percent difference between experimental group and control group, and the no treatment group.

The one method which jumps out from all of our research, and we have looked at over 150 treatment methods, is cognitive behavioral and social learning training, training of social skills, training of problem solving and avoiding thinking errors, training of self-control, anger management, and other social learning and cognitive behavioral training. We have annotated 54 studies of cognitive behavior of social learning programs. The average effect size is 0.13, which is a 13-percent difference.

Now, let's make sure we understand there is a real difference in the nature of the populations that these methods have been applied to. The TC's I was talking about have been applied to the most serious, most difficult offenders, the predatory cocaine heroin users. Cognitive skills have been applied much more broadly, not only to drug abusers but non-drug abusers as well, and it is the most consistent type of treatment in terms of positive outcomes. Far, far dominant are the number of treatment programs that are far more consistent, and their results in terms of reducing recidivism and their studies are better in terms of the degree of confidence we can have in the outcome. So I think this can give you some clues as to where perhaps the best investments ought to be made of congressional dollars, of tax dollars.

The degree to which we can be sure about this is relatively high, and most social scientists, as you know, don't go around talking about a great deal of confidence; they talk about equivocation, for the most part. Having been one for a long time, I can tell you that. But, nevertheless, the majority of the studies clearly point to positive outcomes, which makes me feel very confident that we have technologies that work. Thank you very much.

Mr. BARR. Thank you very much, Dr. Lipton.

Dr. Taxman, if you would clean up for us and briefly summarize the key elements of your testimony, and then we will have questions of the panel. Thank you, Doctor.

Dr. TAXMAN. Thank you very much and thank you for giving me this opportunity to share with you almost 20 years of work in field research in the area of treatment for criminal justice offenders, and more recent work I have also done in evaluating services for substance abusers within the community context.

What I want to do this morning is start from the basis that we have a body of knowledge now that suggests treatment is very effective. As my colleagues this morning have discussed, a number of studies, albeit with some methodological limitations, continue to show that we can get great benefits to the individual and society from using treatment and prevention technologies.

The thing that I guess causes questions to yourselves and others is this notion of how do we institutionalize the good results that

happen within studies; how do we make programs work better in the general framework of how they are delivered in our communities, whether that be in the jail or in a prison or under supervision; or for different types of populations, whether it be moms who are users, whether it be, you know, people who are involved in the criminal justice system, young adults, that is the real question.

My research as of late has focused on looking at the systemic aspects of how systems work and how we can put in place responsive systems of care. I hope that you will consider this because I think one of the things that we often do is assume that if we provide a program, we are going to solve all these problems. As you probably know better than myself, there are no silver bullets in many situations in life. This is one situation with an addictive population where we have to begin to look at how we put in place a system, because one of the things with an addictive population is you have manipulative behavior. You have behaviors of people who do not want to change and often cannot see how their problems have caused problems for themselves and those around.

As Dr. Vereen talked about, this is not only a problem in addictions, it is also a problem in other lifestyle decisions or disorders like diabetes or asthma.

The question becomes, how do we institutionalize it? I have provided a paper for you I did for the Office of National Drug Control Policy, and I have done some summary points that I hope you include as part of the record. But I really want to summarize four different points because I know time is short today.

I also want to talk about how I am drawing upon mostly the experience with criminal justice populations, but as I have been working with the public health treatment community, the same principles can apply in other settings. In fact, I can share with you some pilots that are going on in Montgomery County, MD, right now that deal with welfare moms and mothers under child protective orders that actually use these same four principles.

To begin with, we must look at our treatment system. We have a very fragmented treatment system. Most programs exist on a shoestring. Most programs are episodic. The Haymarket program that was discussed earlier is a unique type of program in the sense it has multiple levels of care. In surveys that we have done in the public health community—we find and this is repeated in the DATOS studies that you are obviously aware of—the majority of programs are outpatient programs that are 3 to 6 months in duration.

What that generally means is you have someone who has an addictive disorder, who is going to an outpatient clinic one to two times a week for a very short period of time, and we are asking people within those settings to begin to address their problems.

The reason that residential programs are attractive, the reason that things called intensive outpatient programs are attractive is because they offer the opportunity to provide more structure and to help someone resocialize and relearn how to live a life without criminal behavior or without substance abuse.

But that is not how the public health systems in most cities and jurisdictions operate. They operate in an episodic program that ba-

sically someone goes into in a short period of time. What we see and what you are concerned about, rightfully so, is the fact we have high dropout rates in these types of programs. They don't engage people; people don't stay with the program.

As part of one of the projects I am involved in, which actually this committee provides support on, is the Washington-Baltimore HIDA. We have a treatment component that has put in place a continuum of care, and the continuum of care concept is the same concept Dr. Lipton talked about, this notion of keeping people in treatment for an extended period of time in multiple phases. It can work from jail to the community, it can work from prison to the community, it can work in the community setting for people under probation or child protective orders in which people are engaged in treatment for a longer period of time.

What we have found in the Washington-Baltimore HIDA project where they instituted in 12 jurisdictions this notion of a continuum, more offenders that have an average of nine prior rearrests and five prior convictions. We have an 85-percent retention rate in treatment, which is remarkable because these offenders have had prior histories of dropouts. We also have seen a very significant reduction in the probability of rearrests.

I can share with you another study we have done, that I have actually done in jails, and they mimic some of the studies Dr. Lipton talked about, about the importance of a continuum. Essentially what we found is when you have jail-based programs with aftercare, you can reduce the rearrest rates by almost 50 percent, and that is very critical as we begin—you particularly begin to think about, you know, the residential substance abuse block grant dollars which limit the funding only to prison environments and do not provide communities with the ability to use some of those funds for those offenders.

The treatment system is an area in which more accountability is needed and more accountability needed in terms of forcing system changes. And I actually applaud efforts that everyone is undertaking right now to develop performance measures, because I think over time that can really improve the quality of services.

Another area that I want to talk about briefly is the area of criminal justice leverage. You have heard a lot about leverage this morning. The question is—as we all talk about coerced treatment, but no one really knows what coerced treatment is—just because the criminal justice system says to someone, "You should go to treatment" does not always mean the treatment provider is providing the same level of coercion or understanding that leverage. We need to work on improving the quality of supervision for clients who are involved in treatment programs.

You have heard a lot of discussions this morning about prisons and jails. I implore you to look at the area of probation supervision. Eighty percent of the offenders involved in the criminal justice system are on probation supervision. Thirty to eighty percent of the entries into jail, or prison, are from revocations from community supervisions. Improving the quality of supervisions for offenders in treatment will make a very large difference in outcomes, reductions in crime and reductions in drug use, and we can't forget that critical component.

Related to that is the notion of sanctions. We heard from Dr. Satel this morning about leverage. We have interests right now about sanctions, and sanctions are, in my perspective, a new way of supervision, of enforcing rules, of making offenders accountable and, I might add, making the criminal justice system and public health system accountable.

I could tell you stories that I have seen in my research that would probably raise some eyebrows about, you know, discharges from treatment programs—no one really knowing, information not being shared—therefore there can't be an opportunity to penalize someone who is not fulfilling their treatment obligations.

Sanctions are similar to the concept of behavior modifications. They are reinforcement of the message of accountability for the offender, as well as within other systems. Sanctions are the potential, and we have seen this in studies in Oregon and in South Carolina, where they apply graduated sanctions to reduce revocations and to reduce intakes into prisons, which have tremendous costs and benefit to society.

Last is this notion of drug testing. Drug testing is a very valuable resource. What I am amazed at is how little funding criminal justice and public health treatment agencies have for drug testing.

I'm working with the State of Maryland—most recently they have reported that they spent about $250,000 on drug testing, 100,000 probationers and parolees, and that is all within their capacity to do. Now the State has put more money into drug testing as they have implemented a new program called Break the Cycle, which is modeled after some of the break-the-cycle programs ONDCP and the Office of Justice programs has been sponsoring.

The critical part of drug testing is to tie it into managing the addicts so you reduce their criminal behavior and their substance abuse, and the only way that can be done is if agencies have the ability to drug-test clients and use that information as a way, as Dr. Satel talked about, of keeping their commitment to treatment. So the whole issue of how we fund drug testing becomes a critical component as we begin to think about these systems.

As part of that, I also think there is a tremendous need to tie together the treatment systems and other systems in terms of sharing information and sharing data about clients that can be used to manage the risk of the substance abuser in the community, and I think that there is a need to begin to look at some of these technologies even more so.

In my brief time this morning, what I have tried to do is outline for you that this protocol of treatment testing, sanctions, and criminal justice leverage can be part of that silver bullet, I guess, if you want to add, to begin to really look at institutionalizing the benefits we can get out of treatment.

Related to that is the need to develop those performance measures. My estimate is that, you know, what we have seen in the CALDATA studies and the RAND studies about the benefits of treatment, if we added the testing, if we added the monitoring and sanctions components with treatment, that we could almost triple the benefits we get out of the treatment dollars that are spent today.

In conclusion, I would like to thank you for this opportunity to share with you some very exciting work and the excitement of the field, actually, from what I hear of public health treatment programs, as well as from criminal justice agencies, with the realization that helping people resolve some of these long-term problems is feasible, if given the proper resources to put some of these pieces in place. Thank you very much.

[The prepared statement of Dr. Taxman follows:]

Getting *to* Results: 12 Easy Steps to Effective Treatment in Crime Control Strategies

by
Faye S. Taxman, Ph.D.
University of Maryland, College Park

Surveys report that the public supports the expansion of drug and correctional treatment services resulting in a policy quagmire. Limited funding for programs results in many programs operating on a "shoe string". Programmatic efforts are fragmented (i.e., episodic, sporadic, etc.), instead of part of a continuous system of care, resulting in many short-term results and little public satisfaction with the results. Less than 15 percent of the offenders receive some type of drug treatment services, even though the general impression is that services are widely available and comprehensive. Yet, research studies continue to affirm that substance abuse and correctional treatment programs duce crime and drug use.

The challenges facing the criminal justice and drug treatment systems are to institutionalize the positive results from the piloted programs. Instead of focusing on a single program, the focus needs to be on developing a responsive, cost-effective system. The time has come to develop a responsive *system* of care and control instead of fragmented services which is outcome driven. Until the criminal justice and health systems develop systems of care that hold substance abusers accountable, the public is unlikely to feel confident in the results from these services. The policy quagmire will continue with low levels of support and continuous questions—while simultaneously realizing that that treatment and correctional programs hold future promise for controlling and changing behavior of those that contribute the most harm to society. The focus needs on strengthening the treatment and correctional systems which has the advantages of reducing crime and the costs of crime to society as well as improving the integrity of the services delivered.

The following discussion will borrow from three efforts to develop and put in place systems that are responsible for long-term behavior change among substance abusing offenders.

- The Office of National Drug Control Policy (ONDCP) has been sponsoring the development of a seamless system of (treatment and sanction) care in 12 jurisdictions as part of the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) program. The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) program implemented a coerced model of treatment featuring quality treatment services, drug testing, and sanctions. The result of the model are that: 1) 85 percent of the offenders completed their first phase of treatment and 65 percent continued into another phase which increased the length of involvement in the treatment process; and, 2) 88 percent of the offenders did not have any involvement in the criminal justice systems (new arrests) during nine months in the community. The average HIDTA client had nine prior arrest and five prior convictions and was rearrested an average of once every nine months. Without the HIDTA approach it is expected that all of the offenders would have been rearrested.
- The state of Maryland has expanded the seamless system concepts into a formal process to institutionalize coerced model of treatment for all offenders in publicly funded treatment programs. Maryland's Break the Cycle program is designed to ensure that the treatment and criminal justice system have the sufficient components of treatment, testing, supervision, and sanctions in reduce crime and substance abuse. Maryland has undertaken a comprehensive approach to formalize processes among the treatment, judiciary, correctional, and law enforcement agencies to prioritize efforts to implement systems of care that focus on long term behavior change.
- The Residential Substance Abuse Treatment block grants are designed to provide comprehensive drug treatment in prison/jail and then continue the efforts in the community. The block grants provide the funding to expand

quality programs in prison and jail. Systems are required to ensure that drug testing and sanctions are used to monitor compliance and reinforce the message of behavior change.

All three efforts—the seamless system in W/B HIDTA, Maryland's Break the Cycle, and the Residential Substance Abuse Treatment (RSAT)—are designed to put in place systems that control the behavior of offenders creating harm to society. Along with other initiatives in the Office of Justice Programs and several states, these initiatives derive from the growing recognition that programs by themselves will falter without supportive structures. An infrastructure is needed that is founded on the principles that produce results of reduced criminal behavior and substance abuse. These structures must ensure that the treatment and criminal justice agencies act in unison to focus on change in behavior.

Background of the Problem

Over five million adults in the United States are under the control of the criminal justice system, either in prison, jail, probation, or parole. These five million Americans account for 50 to 60 percent of the cocaine and heroin consumed in the United States. Addressing the demand for drugs among this population is synonymous with addressing the drug problem in this country—by targeting the addiction problem of the majority of known consumers of drugs, we impact the marketplaces for selling drugs, the associated crime and violence, and improve the quality of life for many communities.

Coerced models of treatment for the offender population, although frequently discussed, have not been implemented within the larger domain of the criminal justice system. The involvement of the criminal justice system is an added bonus because coerced models of treatment engage offenders in behavior changing interventions and settings, control drug use and criminal behavior, and change drug consumption habits.. Since the majority of the offender population receives treatment services from the public health system, it is important that the criminal justice and treatment systems develop a comprehensive coerced model that encompasses the components of effective programs—

continuous treatment services, drug testing, and supervision and sanctions. The coerced model must be reinforced by each system, instead of each system having their own goals and priorities.

Issues Affecting the System of Care

The existing treatment and criminal justice systems often operate with their own priorities and goals. Each system is accountable to itself instead to the other system. In essence this works towards the systems not being held to standards of performance that focus on long term change in the behavior of offenders. The CALDATA and RAND studies found that for each dollar spent on drug treatment saves $7 in criminal justice costs. Drug treatment is so cost effective that the money saved on crimes not committed just while offenders are in treatment is sufficient to offset the costs of treatment. *Seamless systems of care can ensure that for each dollar spent on treatment, testing, and inctions $25 can be saved in criminal justice costs as well as untold amount of public health costs.* The integration of the criminal justice and treatment systems into a systemic approach will improve public health and public safety outcomes.

The public health and criminal justice system have been affected by the following issues:

- Harm reduction has never been a primary goal of the public health substance abuse treatment programs. Instead the programs tend to operate on providing a health service when the client is ready and willing
- Nearly one-third of the criminal justice offenders when offered treatment in the community would prefer jail time. The preference for jail is that jail is perceived as "easier time" instead of being held accountable.
- Many public health substance abuse treatment programs do not want the criminal justice client because the client is perceived as being "difficult client". The first come, first serve service delivery system allows treatment

programs to select clients they would like to serve and "avoid clients with the more difficult problems."

- Retention in treatment is a major problem for all types of addiction programs. Nearly half of the addicts in treatment programs do not fulfill the requires of the program. (According to the recent Drug Abuse Treatment Outcome Study (DATOS) sponsored by the National Institute on Drug Abuse, criminal justice referrals have better completion rates than volunteers for treatment.) Offenders tend to stay longer in treatment as a result of the leverage of the criminal justice system.
- Treatment programs tend to be unstructured and too short in duration for the needs of many addicts. Length of stay in treatment continues to improve outcomes. Most programs are 90 to 120 days in duration and consist of a low level of services (i.e., once a week counseling services). Longer term programs of nine months in duration and more intensive services over a longer period of time are critical to achieving better treatment results. By having program phases or a continuum of care (i.e., two consecutive treatment experiences), jurisdictions can provide comprehensive services in a cost effective manner.
- Supervision and monitoring tend to be understated in terms of their value and importance. It is critically important that the offender be responsible for both treatment and supervision program requires to ensure that long term change occurs. Supervision agencies tend to place little priority on offenders in treatment programs unless the person does not attend the program. Usually the monitoring is lax and does not reinforce the importance of behavior change.
- Treatment and supervision retention can be enhanced by a series of structured responses that punish negative behavior (e.g., non-compliance, positive urines, etc.) and reward positive behavior (e.g., completion of treatment phases, attendance at supervision reporting, etc.)

- Drug testing is not widely available and test results are infrequently integrated into program placement or supervision requirement decisions. Drug testing information should be used to drive the treatment and supervision decisions.

The seamless system approach attacks each component of the disarray among the treatment and criminal justice system through a series of agreed upon protocols. The coerced model is based on treatment and criminal justice agencies functioning as a single agency instead of two separate units trying to "coordinate" and "collaborate" among fragmented services and struggle over who "controls" the client. The system predefines the components of care from each system to develop a package of services that are provided by the respective agencies. This package includes drug testing, continuum of treatment services, and sanctions to respond to non-compliance behavior. Pilot outcomes suggest that system reforms are effective in developing systemic responses to offender behavior. Early findings from the HIDTA evaluation suggest reductions in recidivism and drug consumption.

Components of Care—Responsive Systems

Most jurisdictions do not have an infrastructure in place to deliver long term results—the tendency is to develop single programs (e.g., boot camps, residential treatment, etc.) that are not oriented to a long term behavior change. A responsive system must recognize that the goal of treatment is to reduce harm to society, particularly crime and substance abuse. A responsive system must develop services that focus on long-term change instead of "quick", short term results. Such a system of care requires the treatment and criminal justice system to develop processes that consist of the following:

- Assessment and Diagnostic Capabilities: The ability to understand the driving factors contributing to the offenders "harm" to society. Information on the substance abuse and criminal justice characteristics of the person must be used to determine the nature and type of treatment as well as use restrictions on liberties to control the person. .

- Program Placement Criteria: Placement in a program should be based on the results of the assessment and diagnostic instruments. Program placement should be designed to control behavior (supervision and criminal justice monitoring) and to change behavior (treatment).
- Quality Clinical Interventions focusing on behavior change and prosocial value systems. The focus should be on interventions designed to change behavior. The interventions must meet certain standards including being sufficient in duration to affect behavior changes in offenders and using effective intervention strategies. The focus should be on services that consistent of different levels or phases including aftercare and booster sessions to reaffirm the treatment interventions.
- Quality Oversight and Monitoring through supervision services. Supervision and monitoring services must be considered as part of the treatment protocol. The criminal justice leverage involves using restrictions on liberties to provide external control on the behavior of the substance abusing offenders. Leverage is used to reinforce the importance of long-term behavior change.
- Drug testing to monitor progress in treatment programs. Technology is a critical component of the process of monitoring progress. Drug testing technology provides inexpensive means to determine adherence to supervision and treatment conditions. The results must be used to determine program placement, transition into other levels of care, and amount of restrictions on the offender.
- Sanctions to address non-compliance with treatment programs. Non-compliance with program conditions, both treatment and supervision, threatens public safety and the goals of long-term behavior change. An important component of the monitoring is to use sanctions to modify behavior—by placing constraints on the offenders in responding to infractions, the goal is to exert leverage to deter further non-compliance.

- Rewards to promote positive behavior . A system of sanctions must be coupled with a system of rewards which provides positive incentives for following the program rules and changing behavior. The rewards provide the positive encouragement to make long term behavior.

Treatment is therefore consists of the treatment and monitoring (supervision) that employ both internal and external control strategies to change the behavior of substance abusing offenders. The challenges to putting this system in place involve the criminal justice system (i.e., judiciary, corrections, jail, probation and parole) and the public health treatment system defining systemic processes. These systemic processes will overcome the barriers to good programs by ensuring that treatment and criminal justice systems are committed to ensuring that the process of behavior change (i.e. motivation, commitment, action, maintenance, etc.) are translated into programmatic features.

Twelve Steps to Adopting the Systems of Care Principles

The national strategy identifies treatment as a critical component of reducing drugs consumption in our society. With offenders consuming half of the drugs and nearly half of the slots in public health drug treatment programs, the seamless system model of the W/B HIDTA model provides a formula for achieving this goal of reducing drug consumption and crime in our most affected communities. Dealing with the offender population requires a systemic approach that includes the following components:

- Reducing crime needs to be the goal of the public health treatment and criminal justice agencies
- Using policies focused on controlling behavior of offenders and addicts is critical to implementing seamless treatment and criminal justice systems
- Functioning as a seamless team is needed to manage the risk of the addict offender
- Using drug testing as a tool to manage offender behavior and measure progress in treatment and supervision

- Ensuring that offender populations served by the treatment system are "high risk" offenders with large daily addiction habits. By serving this population, the communities will benefit from the reduced harm posed by the hard core addict
- Matching services with offender needs is critical to achieve the largest benefits in terms of crime and drug consumption problems ;
- Extending the length of treatment through a continuum of care will yield better retention rates and longer term outcomes
- Using behavioral contracts to bind the offender, treatment system, and criminal justice system to expectations is critical to achieving outcomes
- Designating special supervision agents will ensure that the leverage of the criminal justice system is present;
- Addressing non-compliant behavior in a timely and responsive process through sanctions will ensure that the leverage of the system is used appropriately to achieve public safety and public health goals;
- Using rewards for compliant behavior will reinforce the systems commitment to treatment as a crime control strategy
- Focusing on quality of services is critical to achieving long term outcomes. The tendency to provide less services to more addicts has diluted the impact of treatment and created serious concerns about treatment as an effective crime control tools. Quality testing, treatment, and sanctions will alleviate this perspective and demonstrate the value of community based health and safety programs.

Effective treatment services are synonymous with effective criminal justice services. The seamless system protocol provides a systemic process to address some of the inadequacies of the existing service offered by treatment and criminal justice agencies. It removes discretionary practices and institutionalizes operations to address the traditional barriers to treatment for offender populations. Many scholars, policy makers, and practitioners highlight how critical it is to provide good treatment services to ensure that

The public has confidence in criminal justice policies. Through the seamless system approach it is feasible to ensure that these policies become operational.

Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community

Prepared for:

Office of National Drug Control Policy
Treatment and Criminal Justice System Conference

February 20, 1998

Prepared by:

Faye S. Taxman, Ph.D.
Associate Research Professor
Coordinator, Treatment and Criminal Justice Supervision
W/B High Intensity Drug Trafficking Area (W/B HIDTA)
University of Maryland, College Park
7500 Greenway Center Drive, Suite 900
Greenbelt, Maryland 20770
301-489-1700.

The Washington Baltimore High Intensity Drug Trafficking Area (HIDTA) project is funded by the Office of National Drug Control Policy under grant number I7PWBP528 Special thanks are given to the administrators and staff from the participating agencies as well as the W/B HIDTA including Mr. Stephan Sherman, Mr. Dennis McCarthy, Ms. Christine Depies, Mr. Bruce Kubu, and Mr. Tom Carr for their assistance in this project. Dr. Dorothy Lockwood also contributed to this paper. Special appreciation is given to Ms. Nancy Ford and Mr. James Mora for their assistance in preparing this paper. Points of view in this document are those of the author and do not necessarily represent the official position of any agency. Any questions can be forwarded to the author at 301-489-1705 or ftaxman@bss2.umd.edu.

Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community

Over five million adults in the United States are under the control of the criminal justice system, either in prison, jail, probation, or parole. These five million Americans account for 50 to 60 percent of the cocaine and heroin consumed in the United States. Addressing the demand for drugs among this population is synonymous with addressing the drug problem in this country—by targeting the addiction problem of the majority of known consumers of drugs, we impact the marketplaces for selling drugs, the associated crime and violence, and improve the quality of life for many communities. The involvement of the criminal justice system is an added bonus because coerced models of treatment engage offenders in behavior changing interventions and settings, control drug use and criminal behavior, and change drug consumption habits.

Coerced models of treatment for the offender population, although frequently discussed, have not been implemented within the larger domain of the criminal justice system. The tendency is to implement programs to serve smaller populations rather than the masses of offenders that need treatment interventions. Less than 15 percent of the offender population receive some type of treatment services, although the majority of the services are self-help groups and drug/alcohol abuse education (CASA, 1998; Peters, et al., 1992). The attractiveness of program concepts such as boot camps, drug courts, jail and prison based treatment, day reporting programs, and others continues the tradition of trying to deliver treatment services to a small percentage of offenders. The focus on programs, instead of systemic policies and

practices, negates efforts to provide widespread and effective treatment services in all domains of correctional control (e.g., jail, prison, parole, and probation). It reduces even more the likelihood that offenders will receive services as they move through the criminal justice system.

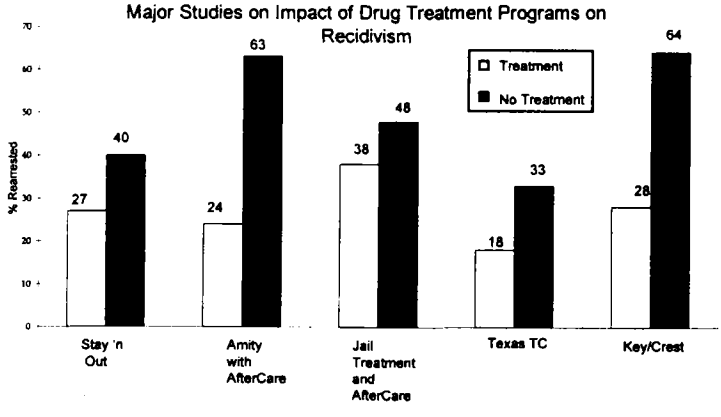
The vast number of studies on drug treatment over the last 20 years has clearly demonstrated that drug treatment is a powerful tool in the "war on drugs" in *all* correctional settings. The effectiveness is enhanced when offenders are provided treatment in jail/prison, balanced by continued treatment in the community (Lipton, 1995; Taxman and Spinner, 1997). In order to have an impact on the drug problem, drug treatment must be offered as a general practice instead of on an isolated basis. Research has identified the components of effective treatment programs that reduce drug use and criminal behavior. These research studies illustrate how treatment services, in conjunction with drug testing, supervision, and immediate consequences (sanctions), are critical components of an effective treatment delivery system.

This paper presents a systemic case management model of substance abuse treatment, testing, and sanctions for offenders implemented as part of the Washington/Baltimore High Intensity Drug Trafficking Area (W/B HIDTA) project sponsored by the Office of National Drug Control Policy (ONDCP). The focus of this effort is to reduce recidivism and drug consumption among hard-core users of drugs, or offenders. This paper has four purposes: 1) to provide an overview of treatment as a crime control measure; 2) to present the typical barriers to offenders receiving treatment; 3) to identify core components of the W/B HIDTA seamless system of care, particularly for transition services; and 4) to identify the core principles of successful treatment and transition interventions.

Treatment As A Crime Control Tool

A growing body of empirical studies illustrates the impact of drug treatment services on offender criminal behavior and drug use. These studies continue to demonstrate that drug treatment is a viable tool to address the drug consumption and criminal behavior habits of offenders. The studies, as shown in Exhibit 1, show that offenders participating in drug treatment services are less likely to be rearrested or return to jail/prison than similar offenders who are not participating in drug treatment services. The importance of these findings is the consistency across treatment programs offered in the community, in prison, or in jail. As noted by Duffee and Carlson, "drug treatment programs are so cost effective that the money saved on crimes not committed *just while offenders are in treatment* is sufficient to offset the costs of treatment" (1996:585). Drug offenders, when offered drug treatment services, have better outcomes.

Exhibit 1:
Major Studies on Impact of Drug Treatment Programs on Recidivism



Source: Simpson, 1997; Taxman and Spinner, 1997.

The good news about drug treatment is that drug offenders, when offered drug treatment services, have better outcomes than offenders who do not participate in the programs. Drug treatment services both reduce the incidence of criminal behavior and increase the overall length of crime-free time for offenders. Exhibit 2 illustrates this impact in a study of offenders that participated in a jail-based treatment program that included a continuum of care. Of the offenders participating in the jail drug treatment program, 38.5 percent were rearrested within 24 months after release from jail compared to 48.7 percent of the comparison group. The average offender participating in jail and community treatment took an average of 282 days to be rearrest compared to 201 for the comparison group, or an 81 day difference (Taxman and Spinner, 1997). Treatment has the added benefit of slowing the spread of AIDS, increasing employment opportunities, and reducing societal costs of addressing abhorrent criminal behavior and substance abuse.

Exhibit 2:
Impact of Jail Treatment, Community Treatment, and
No Treatment on Recidivism (24 Months Follow-up)

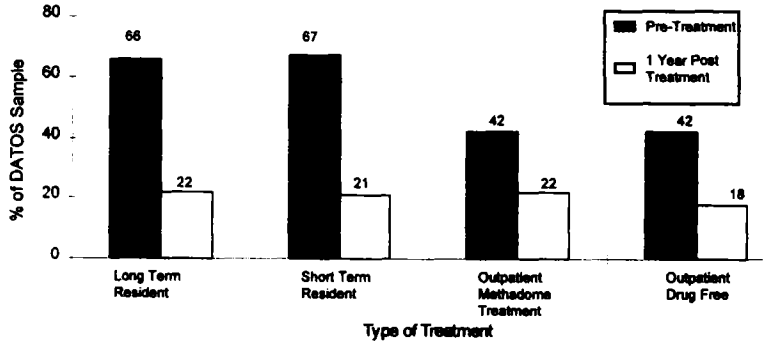
Group	Predicted Probability of Rearrest	Predicted Probability of Rearrest and Technical	Length of Time to Rearrest (days)
Jail Treatment Only	34.5%	55.0%	233
Jail/Community Tx	24.0%	36.00%	282
No Treatment	48.5%	68.00%	201

Source: Taxman, F and D. Spinner, 1997. *Jail Addiction Services (JAS) Demonstration Project in Montgomery County, MD.* University of Maryland, College Park.

Participation in drug treatment contributes to a significant reduction in the frequency of use and amount of drugs consumed. In the most recent Drug Abuse Treatment Outcome Study (DATOS) funded by the National Institute on Drug Abuse (NIDA), declines in drug use were reported for all treatment modalities. DATOS collected data on over 10,000 clients admitted to outpatient methadone treatment, short-term inpatient, long-term residential, and outpatient drug-

free programs in 1991-1993. Follow-up data was collected on 3,000 clients one year after treatment. As shown in Exhibit 3, weekly drug use declined significantly between the pretreatment stage and the follow-up stage in all treatment modalities. In methadone treatment, daily or weekly heroin use fell from 89 percent at pretreatment to 28 percent at follow-up; cocaine use fell from 42 percent at pretreatment to 22 percent at follow-up. In other treatment modalities, clients reported at least a 50 percent reduction in weekly or daily cocaine use compared to the pretreatment stage (Hubbard, et al., 1989; Simpson, et al., 1997b). In the W/B HIDTA study of 571 offenders participating in drug treatment for at least nine months, the researchers found that all of the offenders tested positive prior to treatment, with an average of 13 percent testing positive for drug use while in treatment (W/B HIDTA, 1997). Prior studies illustrate that when drug addicts are not actively using drugs, they are not engaging in criminal activity. In fact, Nurco and colleagues (1988) found that addicts in drug treatment were 75 percent less likely to commit crimes than when they were using drugs.

Exhibit 3:
Self Reported Drug Use Among Addicts Participating in Treatment (Cocaine Use)



Source: Simpson, D., et al., 1997. "DATOS First Wave Findings Release," Research Roundup. Texas Christian University: Institute of Behavioral Research

Skeptics of drug treatment cite doubts about the overall performance of the drug treatment system as evidence that treatment is not appropriate for offenders. A general impression is that drug treatment does little to change the behavior of addicts. High drop-out rates from drug treatment programs and relapse rates fuel concerns about ineffective services, with an average of 50 percent of addicts completing their course of treatment (Simpson, et al., 1997b). Such critics fail to recognize, however, that offenders have higher completion rates than volunteers for treatment services. Offenders also stay in treatment longer, complete treatment programs, and report less drug use while in treatment programs than voluntary addicts in treatment (Simpson, et al., 1997; Hubbard, et al., 1989). In other words, while many use the overall experience of the treatment system to support the position that offenders do not deserve treatment, offenders benefit from treatment services and society benefits from offenders participating in treatment by less criminal behavior. The leverage of the criminal justice system can be used to improve public health and public safety outcomes.

Typical Barriers to Treatment; Added Bonuses of Providing Treatment for Offenders

The integration of drug treatment into the criminal justice system has been a struggle that underscores differing philosophies about criminal offenders, recovery, rehabilitation, and the value of leverage in changing the behavior of offender/addicts. Both the treatment and the criminal justice systems have struggled with allowing each other to achieve their own independent goals. The conflicting priorities and practices of the criminal justice and treatment systems often impact offenders accessing treatment programs, being placed in appropriate treatment programs, and using the leverage of the criminal justice system to retain the client in treatment. Many myths about treating offenders exist because of the failure of the treatment and

criminal justice systems to develop systemic approaches to address common, but not insurmountable, issues. Some of the issues frequently cited as barriers to treatment for offenders are outlined below; research and good practices have generally countered these barriers.

TREATMENT IS PERCEIVED AS AN OPPORTUNITY, NOT A PUNISHMENT. While the criminal justice system has the goal of protecting society and reducing the risk from offenders, the public health system is primarily charged with the goal of providing services to improve health and social productivity. Harm reduction, in terms of criminal behavior, has never been a primary goal of treatment programs. It is only within recent years that the public health treatment system has realized that treatment can be part of the strategy to reduce the demand for drugs and reduce criminal behavior. While treatment is not considered punishment, the coerced treatment model allows treatment to be a tool of the criminal justice system to deter drug use and crime. A related concern is that treatment is not punishment. Treatment programs are often portrayed as easy, minimally intrusive, and a privilege. The very nature of the treatment process requires addicts to change their lifestyles, behaviors, and daily habits. The treatment program restricts freedom by limiting the activities of the participants, limiting peer association, changing residence, and requiring participation in a variety of activities such as self-help groups, community service, etc. A recently noted trend emerging from several studies shows that 25 to 35 percent of offenders offered some the type of correctional treatment program refused the program with a preference for jail time (MacKenzie and Souryal, 1994; Petersilia and Turner, 1993). That is, offenders prefer incarceration to participation in a treatment program because the jail time is "easier time" than being held accountable for their behavior. Defense attorneys have commented that drug treatment programs are a risk for their clients because failure to comply with the program may result in clients serving more incarceration time (Taxman, 1994).

THE CRIMINAL JUSTICE OFFENDER IS OFTEN UNWANTED IN THE TREATMENT SYSTEM.

While slightly less than 15 percent of the offender population is actually engaged in treatment services[1] (Drug Policy Strategy, 1996), one of the major stumbling blocks is that many public health agencies do not want to treat the criminal justice client. As discussed by Duffee and Carlson (1996), the attitudes and values of the treatment system often preclude prioritizing different populations for services. Part of this attitude derives from community agencies having their own perspective of the ideal client/offender, while the other part derives from the criminal offender being perceived as a "difficult client". Often, reporting to the court or probation agency is viewed as an additional burden that treatment programs do not want to handle.

With the exception of pregnant women and HIV active addicts, the first-come, first-served model of treatment services prevails in the public health system. Under the first-come, first-served model, everyone is viewed as equally needy for care. Addicts appearing at the door of the treatment program are accepted based on program-specific criteria which often do not include societal harm (e.g., criminal behavior) posed by the client. Under this model, it is easy for the treatment program to provide services to some sub-populations and not provide services to others. As noted by Schlesinger and Dorwart, the first-come first-served public health model allows treatment programs to select the clients they would like to serve and "avoid clients with the most difficult problems" (1993:224). Waiting lists are believed to be an artifact not only of clients needing services but of the organizational structure of the drug treatment provider system to pick and choose clients. There is no triage system in place to prioritize the type of addict that

[1] Treatment services here include self-help groups, educational groups, therapeutic communities, group therapy, individual counseling, etc. Most of the services provided to offenders can be categorized as self-help groups and educational groups. The actual percentage of offenders that participate in clinical interventions is much smaller than 15 percent of the offenders participating in any treatment services.

should receive care based on societal harm, matching of client to program, or any systematic process.

VOLUNTEERS ARE CONSIDERED MORE MOTIVATED THAN OFFENDERS, YET OFFENDERS HAVE BETTER TREATMENT COMPLETION RATES. A common myth is that the "treatment volunteers" are more motivated, and thus more willing, to change their behavior than addicts coerced into treatment. This assumption has not been substantiated. Research has shown that criminal justice offenders in treatment are more likely to complete their treatment than volunteers (Simpson, et al., 1981; Hubbard, et al., 1989). Most addicts do not "volunteer" for treatment services without some precipitating factor (such as the employer, the family or life partner, or some life crisis) to prompt the addict to seek treatment. These factors drive the client to seek treatment, as does the legal system. The "coercive factors" may provide the driving force to begin treatment but they do not provide the continuing pressure for a commitment to recovery. Recent research on motivation of addicts in treatment has shown that the treatment process can contribute to engaging the addict in treatment and motivating the client to change his/her behavior. That is, many clients may not be motivated initially, but the treatment process itself provides the client with tools which lead to a desire to change behavior, as well as to continue with treatment (Simpson, et al., 1997a).

OFFENDERS HAVE HIGHER COMPLETION RATES FROM TREATMENT PROGRAMS, THANKS TO THE LEVERAGE OF THE CRIMINAL JUSTICE SYSTEM. Both treatment and supervision agencies experience problems with compliance with program requirements. Findings of typical treatment programs indicate that at least half of the clients in treatment do not complete the program (Hubbard, et al., 1989). A widely reported problem with public health treatment programs is that dropout rates are typically high and relapse to drugs and criminality among

dropouts is a problem (Hubbard, et al., 1989; Simpson, et al, 1997). Taxman and Byrne (1994) and Cunniff and Langan (1993) estimate that approximately 50 percent of offenders do not meet supervision requirements. Compliance problems create difficulties by reducing the integrity of the treatment and supervision programs.

With the oversight of the criminal justice system, criminal justice agencies have the leverage to motivate the offender to participate in treatment and complete the treatment regime. Studies have found that legal coercion is an important variable for the offender to stick with the treatment program (Anglin and Hser, 1990; Grella, et al., 1994; CASA, 1998). Many new treatment initiatives for the criminal justice client feature graduated sanctions, or immediate consequences for non-compliance. The Drug Court pioneered the sanctions as a tool to encourage completion of treatment programs. The sanctions often involve rewards for good performance as well as punishment for continued drug use and failure to attend treatment programs. Results from the District of Columbia's Drug Court found that offenders are four times *less* likely to continue to use drugs when they are sanctioned (Harrell & Cavanaugh, 1996).

LENGTH OF STAY IN TREATMENT AND A CONTINUUM OF CARE INCREASE IMPROVED OUTCOMES. Length of stay in treatment has been found to be a critical variable in reducing recidivism and substance abuse (DeLeon, et al., 1982; Condelli and Hubbard, 1994; Hubbard, et al., 1989; Simpson, 1979; Simpson and Sells, 1990). Addicts are notorious for dropping out of treatment, especially during the early stages of a program when the addict is adjusting to a non-drug use lifestyle. Treatment programs have a difficult time engaging the client in treatment for a period sufficient to affect the behavior of the client. With high drop-out rates, it is difficult to achieve the desired outcomes of reduced consumption of drugs. The criminal justice involvement has the benefit of having an active, outside force to monitor compliance with

treatment programs. Encouragement and reinforcement of the importance of the treatment program are part of the means to continue to engage the client in behavior change.

Managed care and cost containment efforts have led to shorter treatment programs, which result in reduced length of stay in treatment. A continuing trend in the field is minimizing services and reducing the length of time clients are in treatment (Etheridge, 1997). The implications for the future of this trend are unknown. However, researchers have supported the proposition that offender populations, due to the societal harm of criminal behavior, should participate in a minimum of one year of treatment (Lipton, 1995). It is recommended, as previously discussed, that treatment can be achieved by providing services in jail and/or prison and then continuing treatment in the community. Providing for a continuum of care is one systemic process to increase the length of time in treatment by having offenders participate in different phases of treatment. The concept of a continuum extends the length of treatment while adjusting the intensity of the services based on the progress of the client. Several continuum models have been adopted: residential, jail or prison treatment, followed by outpatient; intermediate care (28 day residential) with intensive outpatient and outpatient; intensive outpatient and outpatient; and outpatient and aftercare. The continuum of care model provides the client with longer stays in treatment (up to 12 months), while reducing the costs of delivering services.

RECOGNIZING TREATMENT AS CRIME CONTROL IS GOOD PUBLIC POLICY. The coerced treatment model a crime control approach focused on behaviors that contribute to the criminal activity. By focusing efforts on offenders under supervision (e.g., probationers and parolees, in jail or prison), the behavior of these offenders can be monitored. Treatment is used to change the behavior of the offender by engaging the offender in services that address the substance abuse

factors that drive criminal behavior. Treatment becomes the cornerstone of the sentence by reinforcing the importance of behavior change for the offender. Since the offender is under the control of the criminal justice system, oversight measures can be used to monitor the behavior of the offender. Drug testing is a favored technique to determine whether the offender is using drugs (Visher, 1990). Constant supervision and contacts with the addict is another mechanism to determine progress and then adjust treatment and criminal justice program components. Compliance measures (graduated sanctions) become tools to monitor the progress of the client and assist the offender in maintaining his/her commitment to recovery.

Moving from an Individual Case Management Approach to Systemic Case Management

Prior experience shows that providing treatment services for the criminal justice offender has been hampered by traditional barriers within the treatment and criminal justice systems. Traditionally, the criminal justice system has approached treatment as a brokered service, with the criminal justice system acting as a liaison by referring offenders for needed services. The perception of the criminal justice system has been that the treatment system has not met the needs of its clients (Cowles, et al., 1995; Duffee and Carlson, 1996). To address these unmet needs, the favored response has been to create case managers to bridge the criminal justice and treatment systems (Swartz, 1994). The underlying notion was that these case managers would provide the function of screening and assessing clients; they would work with the criminal justice system and treatment system to address differing philosophies and goals. The goal was for the case manager to be involved in issues of treatment placement, treatment plans, and non-compliance.

Recent research on demonstration projects involving the case management approach has not been as promising as expected (Martin, et al., in press; Taxman, et al., 1995). In the typical setting, the case manager is perceived as a supplement to the treatment process (Samson, et al., 1979) with case management services considered ancillary. The case manager often plays a critical role in the screening and assessment, but has a minimal role, if any, in treatment planning and treatment decisions (Sullivan, Hartmann, Dillon, and Wohl, 1994). For example, the Treatment Alternatives to Street Crime (TASC) evaluation recently found that case management is a diverse function that varies widely depending on the organizational structure; some case managers provide screening and assessment services and others are involved in actual treatment delivery (Anglin , et al., 1996). Anglin and colleagues found that case managers do not necessarily remain involved in treatment planning once the offender entered a program. Several studies found that the role of the case manager was often unclear (Shwartz, et al., 1997) and that the case manager seldom consulted with parole officers to establish treatment goals for the offender (Martin, Inciardi, and Isenberg, 1993). Inciardi and Martin (1994) also noted that case manager roles parallel desired supervisory functions of probation and/or parole officers, which results in minimizing the role of the parole officer to monitor the offender when the case manager assumes such supervisory functions.

An overriding issue on case management is that the case manager's role is generally not perceived as a system function, but merely one of many actors involved with a client. The case manager role essentially is marginal, since each agency continues to act on its own accord. The client tends to have three interested parties—the supervision agent, the treatment provider, and the case manager—which creates difficulties when there are conflicting goals and expectations. Often this results in the client trying to resolve the conflict. In this scenario, each agency continues to function as if it is the only system, instead of an integrated part of a total system of care for the

individual client. Studies have also found that individual case management practices do not produce system-wide changes because most case mangers cannot influence the distribution of resources available "within their local delivery systems" (Austin, 1993:453).

For the past ten years, researchers have identified a number of system features that are critical to effectively use treatment for offender populations. Primarily evolving from the individual case management movement (e.g., the Treatment Alternatives to Street Crime (TASC)) and the experiences of Stay 'n Out and other treatment initiatives for offenders, the following have been identified as critical components for an effective systems approach to treating the drug offender (Wexler, Lipton, & Johnson, 1988; Prendergast, Wellisch, and Anglin, 1994; Taxman and Lockwood, 1996; Taxman and Spinner, 1997; Anglin and Hser, 1990):

- Offenders must be assessed in terms of severity of drug use and propensity to commit crimes.
- Treatment placement should be made depending on the severity of drug use and propensity to commit crimes.
- Treatment must include an intensive component, followed by less intensive treatment, and then aftercare. The most effective treatment process is twelve months of care.
- Supervision and monitoring of the requirements are critical to improving treatment outcomes.
- External controls of supervision services (e.g., face-to-face, curfews, electronic monitoring, day reporting, etc.) should be used to control the offender in treatment and/or supervision programs.
- Sanctions or compliance monitoring should be used to deter clients from further drug use.
- Drug testing is critical to monitor drug use and deter offenders from further involvement in drugs.

The systemic case management approach integrates the above system features within the criminal justice and treatment systems as part of the ongoing processes for handling offenders. The systemic approach focuses on resource development, social action plans, policy formation,

data collection, information management, program evaluation, and quality assurance (Austin, 1993). A systemic approach integrates traditional case management functions within the roles and responsibilities of the appropriate treatment and criminal justice staff. A third party is not responsible for performing these functions; instead, the treatment and criminal justice agencies function as a single agency instead of two separate units that try to "coordinate" fragmented services and constantly struggle over who "controls" decision-making about the client. The system predefines the components of care--testing, treatment, and supervision--that will be provided by the different agencies.

The cornerstone of a systems approach is that services consist of a process of interconnected parts. Treatment (e.g., therapeutic interventions, psychosocial education, etc.) and criminal justice services (e.g., supervision, sanctions, community service, drug testing, electronic monitoring, house arrest, etc.) have specific value and meaning in the process. Rather than mere coordination, there is integration and synthesis in both policies and implementation. The systems approach lends itself to building the infrastructure to support the functions of a service delivery system with clearly defined policies relating to: assessment, referral, placement, tracking and monitoring, service planning, transitioning into the next level of care, appropriate service mix during all phases in the system, and discharge.

Lessons from the W/B HIDTA Seamless System of Treatment, Testing, and Sanctions

The purpose of the W/B HIDTA is to reduce the demand for drugs within the targeted jurisdictional area. As part of the mission, a treatment and criminal justice component assists with reducing the criminal behavior and the demand for drugs among hard-core substance

abusing offenders, who typically recycle through the criminal justice system. By developing a systemic case management system between the criminal justice and public health systems, each jurisdiction is achieving these goals and objectives by establishing policies and practices in key areas: target population for treatment; appropriate treatment placement; drug testing; continuum of care; supervision; and sanctions or consequences for negative behavior. The common W/B HIDTA system goals are:

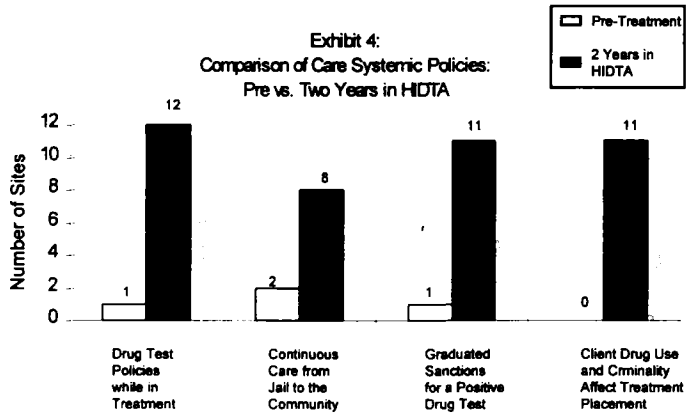
- To establish a "seamless" system between criminal justice and treatment agencies;
- To provide a continuum of care for the target offender population;
- To use drug testing to monitor performance in treatment and criminal justice supervision; and,
- To develop and implement graduated sanctions policies to increase compliance with the conditions of treatment.

Each jurisdiction uses these general goals to develop its seamless system. The seamless system is built with either a combination of jail-based treatment connected to treatment in the community, residential treatment with intensive outpatient, or intensive outpatient with outpatient care. The drug testing and sanctions with designated agents are common features in each jurisdiction.

Need for Policy Development

Exhibit 4 illustrates the progressive development of seamless system policies in the twelve jurisdictions participating in the W/B HIDTA. Prior to the W/B HIDTA, very few of the jurisdictions had drug testing policies, graduated sanctions, or a practice of a continuum of care that integrated treatment and criminal justice functions. As the jurisdictions participate in the project, more and more are adding components of the seamless system. The evolution of the seamless system concept is integral to changing management of the substance abusing offender

in the community. The more treatment and criminal justice agencies agree on the principles of care for the individual, the better the expected outcomes. This explains the 85 percent retention rate in treatment for W/B HIDTA clients compared to a 50 percent rate for non-W/B HIDTA clients (Taxman, 1997). The core concepts are described below.



Source: Taxman, F., et al., 1997. "Case Studies of HIDTA Treatment and Criminal Justice Implementation," University of Maryland, College Park.

In a survey of jurisdictions participating in the W/B HIDTA, the researchers found that the existing policies and practices of treatment and criminal justice agencies did not specify the components of care of each system (e.g., treatment, criminal justice agencies, etc.). The treatment and criminal justice systems in these twelve jurisdictions had very little infrastructure in place to identify the types of offenders that should be prioritized for treatment services, the responses to positive urinalysis results, and drop-outs from treatment. For example, in one jurisdiction, very few of the sentenced offenders were receiving treatment services in the community. Instead, available treatment slots were being consumed by pretrial offenders who tended to quit treatment shortly after court disposition. Few stayed in treatment for more than 60 days, with an overall 66 percent

drop-out rate (W/B HIDTA, 1997). A change in the screening and review process resulted in more sentenced offenders staying in treatment. This has also reduced the drop-out rates from treatment programs, since offenders are being closely monitored for treatment compliance.

Another area with little formal policy is drug testing. With the exception of the District of Columbia's Drug Court, none of the jurisdictions had a mechanism for sharing drug testing information between the treatment and criminal justice agencies. Many of the treatment programs refused to provide drug test results to criminal justice agencies as a matter of practice. If an offender is in treatment and tests positive, the treatment agency seldom informs the criminal justice agency until the end of the treatment program. Similarly, if clients are discharged from treatment, the criminal justice agency is usually informed within a three month period. These examples illustrate how the systemic case management approach addresses the linkage between the criminal justice and treatment agencies. By focusing on the typical problem areas—who gets access to treatment services, what should happen if the offender does not comply, and what type of information is useful to share among the agencies—the partnership is stronger. Failure to address these policy and practical issues has an impact on the public perception of the viability of treatment as an option for offenders.

The treatment continuum of care was also not a typical process. In ten jurisdictions, a process did not exist for moving the client along the treatment continuum of care. That is, if the offender participated in a jail-based treatment program, the system did not transition the offender to treatment services in the community. The jail-based treatment programs did not provide discharge services that included placement in a treatment program in the community. In fact, like other jail projects (Swartz, et al., 1996), many of the W/B HIDTA sites did not have good selection procedures. Often offenders participating in the jail treatment program are sent to prison after

completion of the jail treatment program. The benefits from treatment will not be realized since these offenders are not likely to obtain treatment services in the prison systems. As part of the W/B HIDTA program, many jurisdictions developed selection criteria for the jail program that include the likelihood of the offender returning to the community, the offender having a minimum sentence in jail to participate in the program (which reduces early drop-outs), and the offender being on probation. These criteria provide policy guidance to facilitate the continued treatment after release. Treatment planning for the community started as part of the jail treatment program. At several sites, probation/parole agents were assigned to the jail program to begin the transition to the community. Treatment programs in the community were selected to ensure that the offender had a ready placement. Policies were developed both in terms of target population and the transition approach to ensure that offenders participating in jail treatment were eligible for community treatment programs and placement followed release from jail.

Evaluation Findings

The question arises as to the impact of policy development on the two goals of treatment: retention and recidivism for clients. As part of the evaluation, the researchers have tracked over 1,700 offenders that have been exposed to the seamless system concepts of a continuum of care, graduated sanctions, and drug testing. This is an early stage of the development of the seamless initiatives with most features in place for slightly over one year. Preliminary findings illustrate how seamless policies can improve client outcomes.

CHARACTERISTICS OF OFFENDERS IN TREATMENT. The average W/B HIDTA client is 33 years old and male, with 69 percent African-American and 26 percent Caucasian. The primary drug of choice is crack cocaine (43 percent) and heroin (28 percent). Twenty (20)

percent indicate that they are intravenous drug users; the majority smoke or inhale their drugs. Over 69 percent of the offenders reported using drugs at least daily with half of those indicating more than once a day use of drugs.

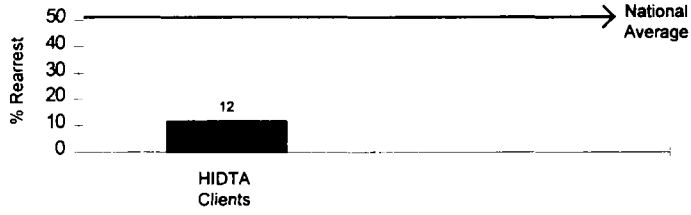
The average W/B HIDTA offender has nine prior arrests and five prior convictions. The arrest history is indicative of offenders that have multiple experiences with the criminal justice system. For the instant offense, 23 percent of the offenders had a property crime, 18 percent were arrested on possession of drugs, 26 percent were arrest for distribution or intent to distribute drugs, and 10 percent had a violation of probation/parole.

RETENTION IN TREATMENT. One purpose of the seamless system approach is to improve retention in treatment programs. As previously indicated, nearly 50 percent of the addicts in treatment drop out of treatment (Simpson, et al., 1997b). As part of the W/B HIDTA treatment initiative, we found that 72 percent completed the first phase of treatment and 62 percent continued treatment in the second phase. The overall retention rate in the treatment process is 85 percent, which is based on the results for over 1700 offenders, many of whom are still active in the treatment process.

REARREST RATES DURING 9 MONTHS OF SUPERVISION WHILE IN TREATMENT. To assess the impact of the process on rearrest rates, the evaluators collected rap sheets for 571 offenders who have participated in the W/B HIDTA treatment. This includes only offenders who are in the community for 9 months. All program participants (e.g., including drop-outs) are included in the sample. Prior to participation in the seamless system, the average HDITA client was arrested once every 9 months. The base rate for rearrest rates for multiple offenders is 50 percent. With the W/B HIDTA process of a continuum of care, testing, and sanctions, the researchers found that 12 percent of the offenders were arrested for new crimes during 9 months

in the community. As shown in Exhibit 5, this is significantly less than was expected given the history of the clients. The retention in treatment, as previous research has demonstrated, appears to be reducing criminal behavior.

Exhibit 5:
Percent of Offenders Rearrested During Nine Months of Community Supervision



Source: W/B HIDTA, 1997

Twelve Principles for Effective Systems of Care Focusing on Transitional Policies and Treatment Retention

The underlying functionality of the treatment and criminal justice system in any region will largely determine the results of individual treatment programs for offenders. Below are the principles of effective systems of care that are designed to: 1) reduce recidivism, and 2) increase retention in treatment programs. These two goals are commingled to allow quality treatment to impact reductions in recidivism. Providing good quality treatment has been demonstrated to reduce recidivism (Anglin & Hser, 1990; Wexler, et al., 1988; Lipton, 1995; Taxman & Spinner, 1997; Inciardi, et al., 1996; Knight, et al., 1997; CASA, 1998). The question is: what are the most effective approaches to achieve reductions in recidivism?

RECIDIVISM REDUCTION SHOULD BE THE GOAL OF THE CRIMINAL JUSTICE AND TREATMENT SYSTEM. Under the current arrangement, treatment and criminal justice systems have two differing goals, neither of which is directly focused on reducing recidivism. Having a

stated goal of treatment and criminal justice supervision to reduce recidivism focuses interventions on this goal. The emphasis on recidivism reduction brings the systems into alignment, requires each to rethink operations and priorities for the agencies individually and operating jointly, and reallocates resources. By examining the current distribution of resources, the efforts are on how best to deliver effective services (instead of any services) to achieve the goal of reducing recidivism.

TREATMENT AND CRIMINAL JUSTICE SYSTEM FEATURES MUST BE POLICY DRIVEN. The seamless system features—integrated screening, placement, testing, monitoring, and sanctions—do not typically exist. The recognition that these policies are critical to effective service delivery requires the systems to develop supporting policies, as described below.

A policy-driven forum is needed to develop and implement targeted policies and practices. Various players of the system, including administrators of the treatment/health, probation and parole, jail, law enforcement officials, judges, court administrators, and other criminal justice or social agencies, must work together as a policy team. Often the inclusion of representatives of the executive and legislative bodies is very important to develop a consensus on policies to make system-wide changes. The policy team approach is a critical component to addressing system issues that tend to be grounded more in tradition than in effective practices. Since it is often difficult to obtain interagency consensus around a common goal like recidivism reduction, the goal provides a mechanism to address organizational or turf battles that are perceived as sacred cows (Woodward, 1993). The policy team and goal driven strategy are designed to develop a consensus for the "seamless" system components in each jurisdiction and then develop the surrounding protocols.

TREATMENT AND CRIMINAL JUSTICE MUST FUNCTION AS A TEAM. The work of the policy team is to define and develop policy as well as provide the needed resources. The next step is to carry policy into practice and operation. The policies serve as a guide to operating procedures by providing direction to staff in dealing with ongoing, daily issues. For example, a policy which states that drug test results will be shared between the criminal justice and treatment systems is designed to ensure that both agencies are informed of the client's progress. The policy directs the supervisors and staff to develop a mechanism for sharing drug test information on a timely basis. At the staff level, this removes the potential for individual staff members to make individual decisions about whether or not they desire to share drug test results. It also provides an agency process to share drug test results such as faxing positive results, using interagency automated systems, etc.

A team approach assists the criminal justice and treatment systems to become partners in the care of the individual offender in treatment. Instead of being adversaries, the criminal justice and treatment staff are working together. The policies guide the relationship by specifying the nature of the working relationship in operational terms focused on: target populations, treatment selection, supervision standards, drug test results, and sanctions. Traditional barriers of information dissemination, confidentiality concerns, and uncertainties about how information will be used disappear by working through these issues as a team.

USE DRUG TESTING TO MANAGE OFFENDERS. Urinalysis allows for immediate confirmation of an offender's use of drugs. While it is clearly a tool for both the treatment and criminal justice systems, drug testing results have not been integrated into policies on how to handle offenders. While many systems test offenders, few systems have policies that use drug test results to screen offenders for treatment programs. Even fewer systems have policies in effect

which provide guidelines on how to handle positive drug tests while the offender is in treatment or under supervision. Treatment placement and program compliance are two areas which require standards and practices. Working together as a team will allow the systems to use available drug test resources widely. Funding for drug testing comes from different sources (e.g., treatment programs, probation, courts, etc.). Few agencies are aware of the testing done by other agencies. Additionally, treatment and supervision agencies have different testing schedules, which include the types of drugs that are tested, frequency of taking specimens, and different levels to indicate a positive urine. Since drug test results are seldom shared, the other agency is often unaware of those results or the surrounding factors that affect test results. Drug tests have not been integrated into practice as a tool to manage the offender in the community.

The Department of Justice's recent requirement on drug testing polices for offenders provides an outline of many pertinent issues related to drug testing that need immediate policy and operational attention (U.S. Department of Justice, 1996). At a minimum, treatment and criminal justice agencies need to consider the overall use of testing in the system. For example, which offenders will be tested while in treatment? During the period of supervision? Who will be responsible for the testing? If testing is to be used to manage treatment and supervision compliance, what should be the responses to positive urine results? These are all policy issues that dramatically affect operations. If testing is to be used to detect potential relapses (including involvement in the criminal justice system), then the criminal justice and treatment systems must work together to ensure that their operations support recidivism reduction practices.

TARGET OFFENDERS FOR TREATMENT WHERE TREATMENT CAN "WORK" Targeting is probably one of the most difficult issues in corrections and criminal justice policies. Boot camps, drug treatment programs, intensive supervision, and other correctional innovations have

all experienced difficulties with the targeting problem (Austin, et al., 1994; Byrne, et al., 1992; Andrews and Bonta, 1994). The tendency is often to provide services to "low risk" offenders, which some contend reduces the societal impact of the treatment programs (Andrews and Bonta, 1994). To have an impact on recidivism and drug consumption, the focus should be on offenders that are both addicts as well as criminally active. By definition, this is the individual with significant years of abusing drugs and prior experience with the criminal justice system.

Both criminal justice and treatment issues must define the target definition for secure treatment resources. From the criminal justice perspective, the offender with a prior arrest and conviction history is more likely to be causing harm to the community. That is, offenders' substance abuse habits drive their criminal behavior in such volume that the individual is likely to be committing many crimes. Cautious decisions must be considered in selecting offenders. First, the criminal justice history may also dictate that the offender is likely to be incarcerated for long periods of time. Targeting these offenders is likely to have little impact on crime in the community. Next, the legal status is an important variable. Many pretrial offenders use participation in treatment to convince judges of their sincerity about their substance abuse problems, only to drop out of treatment after the criminal charge has been dismissed or the offender is placed on probation. The focus on the sentenced offender has several advantages, including the offender is more likely to continue with treatment as part of the requirement of supervision, the offender is less likely to drop out of treatment, and the offender is more likely to be motivated to change his/her behavior over the long period of supervision. The recidivism reduction potential is therefore not likely to be realized for those offenders.

From the clinical perspective, treatment should be targeted to offenders who will benefit from the services. Sociopathic offenders are unlikely to benefit from most community-based

treatment programs. For example, the Maryland Department of Public Safety and Correctional Services uses the Psychopathic Checklist - Revisited to identify offenders suitable for treatment. Criminogenic offenders are also unlikely to benefit from programs that do not address the criminal thinking skills and criminal values. While some contend that the offender's motivation should be a clinical factor affecting selection decisions, recent strides in treatment processes illustrate that quality treatment programs can address motivational factors (Simpson, et al, 1997a). The use of standardized instruments to measure personality disorders, psychological functioning, and motivation provide system processes to select offenders for treatment.

Three other treatment issues are the severity of drug use, type of drugs used, and prior treatment experience. Severity of drug use might be an indicator of need, with priority given to addicts that have daily habits compared to those with less frequent usage patterns (e.g., binge behavior, weekly use, etc.). Similarly, the type of drug abused might also be an important factor in determining priority for treatment given the knowledge that some addicts are more criminally active than others. Finally, prior treatment experience may be a useful variable to determine appropriateness of an offender for a particular type of program. Standardized instruments can ensure that treatment and criminal justice staff collect consistent information on clients, as well as make decisions based on agency priorities. Some agencies use instruments like the Addiction Severity Index as a guide to alcohol and drug problems and use the composite score of 4 and above to indicate criminals who are addicts (Williams and Spingarn, 1997). This practice then assists in targeting addicts for scarce treatment services.

The integration of treatment and criminal justice information in targeting decisions is frequently discussed, but infrequently applied. The difficulty in administering the policy is that treatment and criminal justice agencies do not share information gathered in their respective

disciplines. Often the treatment system does not have criminal justice information, other than self reported criminal justice history. Conversely, criminal justice agencies often rely on the offender to report prior treatment experience and drug use patterns. The focus on recidivism reduction policies will require triaging available treatment slots for offenders that create harm in the community by their drug use *and* criminal behavior. Ultimately, criminal justice and treatment agencies will have to determine how to gather and use information from the different systems to make triage decisions.

USE TREATMENT MATCHING PRACTICES. The tendency of most systems is to place offenders in the first available treatment slots. Often the available "slot" is not suitable for the needs of the offender, but merely reflects an opening. However, using information gathered for targeting purposes, more informed decisions can be made about the type of offender who should be placed in residential, intensive outpatient, and outpatient programs. A mixture of treatment needs and criminal justice risk factors can assist in making this determination. For example, offenders with more involvement in the criminal justice system are likely to require more external controls (e.g., residential or intensive outpatient settings with more structure, etc.) on their behavior as compared to those with less prior criminal justice history. Since many jurisdictions have some services in the jail or prison, consideration should be given to the continuity of care (e.g., suitability of the treatment philosophy and approaches) from the jail/prison program to the community-based program. The American Society of Addiction Medicine has developed a protocol for treatment placement (ASAM, 1991). Although this protocol does not include criminal justice risk factors, policy teams can modify their approaches to incorporate treatment and criminal justice needs.

CREATE A TREATMENT PROCESS AND EXTEND THE LENGTH OF TIME IN TREATMENT. Research continues to affirm the importance of the length of time in treatment for addicts, with better results usually occurring from longer participation in treatment programs. Many short-term residential and outpatient treatment programs are four months or less in duration (Etheridge, et al., 1997); few long-term residential programs (greater than six months) exist. The W/B HIDTA program adopted the continuum of care concept to increase the length of time in treatment for the offender by providing a treatment process of several different programmatic components—more intensive services (e.g., residential, jail/prison-based, day programs, etc.) followed by less intensive, traditional outpatient services. The goal is to engage the offender in treatment for longer periods of time with the treatment process consisting of program phases. The combination of intensive and less intensive services results in a less intrusive treatment environment, as well as being cost effective.

Since most treatment and correctional systems thrive on episodic treatment experiences, policies are required to create the continuum of care practices at the individual level. It is not sufficient to have an array of services without the supporting policies to move offenders through the continuum. These policies need to address the following: 1) establishing a reservation system to alert programs of the expected date of placement in their program; 2) creating a behavioral contract to inform the offender of the likely continuum; 3) establishing criteria for placing offenders in different treatment programs based on progress in the subsequent treatment program; 4) training criminal justice and treatment personnel on the use of a continuum; and, finally, 5) establishing treatment policies which step up or step down the level of care based on progress.

ALLOW BEHAVIORAL CONTRACTS TO BIND THE OFFENDER, THE TREATMENT SYSTEM AND CRIMINAL JUSTICE SYSTEM. A behavioral contract is tool of the treatment and criminal

justice systems to specify the expectations for the client as well as identify treatment and criminal justice services. Informing the offender of the programmatic components clarifies the treatment and criminal justice experiences. Core components of the contract are: 1) treatment programs assigned to and hours of therapy (e.g., each phase or treatment program should be specified, including jail-based treatment programs); 2) supervision schedule and location of supervision agent; 3) drug testing schedule; 4) graduated sanctions to identify set responses to common issues such as positive drug tests and missed appointments; 5) incentives; and 6) special conditions of treatment and/or supervision (e.g., community service hours, electronic monitoring, house arrest, self-help groups, etc.). The behavioral contract should be signed by the offender, treatment provider, and criminal justice agent (and potentially the judge) to serve as a binding contract. The contractual component of the plan requires all parties to be equally committed to the different phases of the treatment and criminal justice protocol.

DESIGNATE SPECIAL AGENTS FOR SUPERVISING OFFENDERS IN TREATMENT PROGRAMS. To become a team with treatment, the probation and/or criminal justice staff must understand the treatment process and support treatment goals. This requires a close working relationship among the treatment and criminal justice staff. The team process in a seamless system relies on the staff to be considerate and supportive of the roles and needs of each discipline. Essentially, specialized agents ensure that a core component of criminal justice staff understand the recidivism reduction principles along with treatment issues.

With a core staff, it is feasible to use the tools of corrections to control the behavior of the offender in the community and to increase compliance with treatment and criminal justice requirements. Probation involves a number of functions that can improve the integrity of the treatment process such as drug testing (to confirm abstinence), collateral contacts (to identify

potential problems in the community, etc.), face-to-face contacts (to observe and discuss treatment progress and compliance with general court conditions), and community service (to help repay society for the crime and to fulfill sentence obligations). In addition, the probation officer can modify most conditions of the sentence (within a range) to intensify the structure should the offender have difficulties in the treatment/supervision or reduce supervision/structure through treatment services. The supervision services offer the potential to enable and facilitate all services by monitoring the offender's performance. Supervision provides the leverage of the criminal justice system to keep the offender in the appropriate treatment services (Visher, 1990; Collins and Allison, 1983).

SANCTION NON-COMPLIANT BEHAVIOR. A cornerstone of recidivism reduction policies addresses the area of non-compliance, or the "what to do with" practices of how to address offenders who fail to fulfill treatment or supervision conditions. Contingency management, token economies, and behavior modification systems are systemic practices that are used in the treatment field to address compliance. Sanctions provide the tools to hold offenders accountable under their behavioral contract. The sanctions are essentially preventive measures to reduce revocations and recidivism, as demonstrated by the D.C. Drug Court (Harrell & Cavanaugh, 1996).

Sanctions policies must have four components. First, the infractions or violation behavior must be clearly identified. By informing the offender of the negative behavior, the process clarifies expectations for the offender. Typical infraction behaviors are positive urine tests, missed appointments in treatment or supervision, and failure to abide by program conditions. Second, the sanctions must be swift, or occur shortly after the behavior at issue. As a rule, it is important to have the sanctions occur within 24 hours of the behavior, which reduces

the denial of the behavior by the offender. Such a policy also requires the treatment and criminal justice systems to respond appropriately to potential crime-producing behavior. Third, the sanctions must be certain or clearly specified, so that the offender is aware of the consequences for violating the treatment and supervision norms. An example of certain responses includes specified days in jail, hours of community service, or increased reporting requirements. The certain responses clarifies for the offender that the lack of compliance will result in a negative response. The final component of the sanction schedule is the progressive nature of the responses. It is unlikely that the response for negative behavior will be the same each time the offender fails to comply. Instead, a sanctions schedule increases in severity as the offender continues to persist in violating treatment and supervision rules. An example is the following: the first positive urine results in one day in jail, the second positive urine results in three days in jail, and the third positive urine results in five days in detoxification. This type of progressive schedule makes clear that the consequences become more severe as the offender continues to persist in his/her negative behavior.

Developing a set of polices that are agreed upon by the criminal justice system will require input from treatment providers, criminal justice actors, and the judiciary[2]. Most treatment programs and probation agencies have their own individualized policies addressing noncompliance with program conditions. In the seamless system, the systems agree on a set protocol as mechanism to reduce recidivism. The agreed-on policies then help to ensure that

[2] The use of sanctions may be affected by the statutory authority of the probation and/or parole agents in a given jurisdiction. In some jurisdictions, probation and/or parole officers cannot incarcerate an offender without approval of the judiciary. In other jurisdictions, the agents have the authority. Since the probation department is generally responsible for executing court orders, the sanction schedules should be developed in coordination with the criminal justice system, particularly judges.

treatment and criminal justice agencies respond appropriately to infractions; this reduces the likelihood that staff will not respond to non-compliant behavior.

REWARD POSITIVE BEHAVIOR. Infrequently the criminal justice system acknowledges positive achievements made by offenders. An incentive system, similar to a sanctions schedule, provides an opportunity to formalize recognition for good behavior so that restraints on the offender are reduced as progress occurs. An incentive system should be swift, certain, and progressive in the same fashion as a sanctions system. The system provides the positive reinforcements often missing from the criminal justice and treatment systems. Positive incentives provide a rationale for the offender to comply with treatment and criminal justice conditions and rewards the attainment of individual goals. In a seamless process, the good and the bad must be equally recognized.

FOCUS ON QUALITY, NOT QUANTITY. The seamless system underscores the importance of policy-driven practices to reduce recidivism. A critical component of recidivism reduction practices is improving outcomes of offenders. Generally this involves ensuring that the treatment and criminal justice systems have the appropriate quality control measures in place to fulfill their obligations. This may require reallocating existing resources to commit to the desired outcomes. It also may result in some short time changes in the number of offenders that can be served through the process. Many agencies operate from a mindset of trying to serve the maximum number of clients possible. Although criminal justice agencies seldom have the opportunity to limit their "clientele", the seamless system process provides the forum to focus on outcomes. Tide to this is the realization that quality programs and services produce these outcomes. That is, each system may determine that existing resources available in the treatment and criminal justice

systems can sufficiently provide quality services to a set number of offenders. Squeezing more clients into the process may dilute its effectiveness.

An important component of quality is in the type of treatment services offered. The tendency of the criminal justice system is to offer less intensive, less expensive services. Self-help groups and educationally oriented services (although valuable service units) dominate the field (CASA, 1998). Yet, to achieve the gains from treatment, other clinical services are needed (e.g., therapeutic community, cognitive behavior skills, milieu therapy, etc.) (Lipton, 1995; Andrews and Bonta, 1994). The focus on outcomes helps systems redefine their service systems on quality or services that are more likely to change behavior. The emphasis on scientifically proven interventions will show gains in better outcomes.

Summary

Effective treatment services are synonymous with effective criminal justice services. The seamless system protocol provides a systemic process to address some of the criticisms of the existing service offered by treatment and criminal justice agencies. It removes discretionary practices and institutionalizes operations to address the traditional barriers to treatment for offender populations. Many scholars, policy makers, and practitioners highlight how critical it is to provide good treatment services to ensure that the public has confidence in criminal justice polices. Through the seamless system approach, it is feasible to ensure that these policies become operational.

References

American Probation and Parole Association and NASADAD. 1992. *Coordinated Interagency Drug Training Program.* Lexington, KY: APPA.

American Society of Addiction Medicine. 1991. *Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders.* Washington, DC.

Andrews, D. A. and J. Bonta. 1994. *The Psychology of Criminal Conduct.* Cincinnati, OH: Anderson Publishing.

Andrews, D. A., I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau and F. T. Cullen. 1990a. "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis." *Criminology* 28:369-404.

Andrews, D. A., I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau and F. T. Cullen. 1990b. "A Human Science Approach or More Punishment and Pessimism: A Rejoinder to Lab and Whitehead." *Criminology* 28:419-429.

Anglin, M. D. and Y. Hser. 1990. "Treatment of Drug Abuse." Pp. 393-460 in *Drugs and Crime*, edited by Michael Tonry and James Q. Wilson. Chicago, IL: University of Chicago Press.

Anglin, M. D., Hser, Y., & Grella, C. E. 1997. "Drug Addiction and Treatment Careers Among Clients in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11:308-323.

Anglin, M. D., D. Longshore, S. Turner, D. McBride, J. Inciardi and M. Prendergast. 1996. *Studies of the Functioning and Effectiveness of Treatment Alternatives to Street Crime (TASC) Programs: Final Report.* Los Angeles, CA: UCLA Drug Abuse Research Center.

Ball, J. C. and A. Ross. 1991. *The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcomes.* New York: Springer-Verlag.

Belenko, S., J. A. Fagan and T. Dumanovsky. 1994. "Effects of Legal Sanctions on Recidivism in Special Drug Courts." *Justice System Journal* 17:53-81.

Byrne, J.M., and A. Pattavina, 1992. "The Effectiveness Issue: Assessing What Works in the Adult Community Corrections Systems," in J. M. Byrne, A. J. Lurigio, and J. Petersilia, *Smart Sentencing: The Emergence of Intermediate Sanctions*, Sage Publications.

Byrne, J. M. 1990. "The Future of Intensive Probation Supervision and New Intermediate Sanctions." *Crime and Delinquency* 36:6-41.

Byrne, J. M., A. Lurigio and C. Baird, 1989. "The Effectiveness of the 'New' Intensive Supervision Programs." *Research in Corrections* 5:1-70.

Center on Addiction and Substance Abuse at Columbia University (CASA). 1998. *Behind Bars: Substance Abuse and America's Prison Population.* New York City, New York: National Center on Addiction and Substance Abuse at Columbia University.

Collins, J. J. and M. Allison. 1983. "Legal Coercion and Retention in Drug Abuse Treatment." *Hospital and Community Psychiatry* 34:1145-1149.

Condelli, W. S. and R. L. Hubbard. 1994. "Relationship Between Time Spent in Treatment and Client Outcomes from Therapeutic Communities." *Journal of Substance Abuse Treatment* 11:25-33.

Cook, F. 1992. "TASC: Case Management Models Linking Criminal Justice and Treatment." Pp. 368-382 in *Progress and Issues in Case Management*, edited by R. S. Ashery. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 127.

Cowles, E. L., T. C. Castellano and L. A. Gransky. 1995. *'Boot Camp' Drug Treatment and Aftercare Interventions: An Evaluation Review.* Washington, DC: National Institute of Justice.

DeLeon, G. 1988. "Legal Pressure in Therapeutic Communities." Pp. 160-177 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

DeLeon, G., H. K. Wexler and N. Jainchill. 1982. "The Therapeutic Community: Success and Improvement Rates 5 Years After Treatment." *International Journal of the Addictions* 17:703-747.

Donovan, D. M. 1990. "Coming Out of the Fog: Professional Practice Issues in the Addictions in the Decade of the 1990s." *Psychology of Addictive Behaviors* 4:42-44.

Drug Policy Strategies, 1997. *Keeping Score.* Washington, D.C.

Duffee, D and B. Carlson, 1996. "Competing Value Premises for the Provision of Drug Treatment to Probationers,' *Crime and Delinquency*, Vol 42 (4): 574-593.

Etheridge, R. M., Hubbard, R. L., Anderson, J., Craddock, S. G., & Flynn, P. M. (1997). Treatment Structure and Program Services in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11:* 244-260.

Falkin, G. 1993. *Coordinating Drug Treatment for Offenders: A Case Study.* New York: National Development and Research Institutes, Inc.

Gendreau, P. 1996. "Offender Rehabilitation: What We Know and What Needs to Be Done." *Criminal Justice and Behavior* 23:144-161.

Gerstein, D. R., R. A. Johnson, H. J. Harwood, D. Fountain, N. Suter and K. Malloy. 1994. *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA).* Sacramento, CA: State of California, Health and Welfare Agency, Department of Alcohol and Drug Programs.

Gustafon, J. S. 1991. "Do More and Do It Better: Staff Related Issues in the Drug Treatment Field that Affect Quality and Effectiveness of Services." Pp. 53-62 in *Improving Drug Abuse Treatment*, edited by R. W. Pickens, C. G. Leukefeld and C. R. Schuster. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 106.

Harrell, A. and S. Cavanagh. 1996. *Preliminary Results from the Evaluation of the DC Superior Court Drug Intervention Program for Drug Felony Defendants.* Washington, DC: National Institute of Justice.

Harwood, H. J., R. L. Hubbard, J. J. Collins and J. V. Rachal. 1988. "The Costs of Crime and the Benefits of Drug Abuse Treatment: A Cost-Benefit Analysis Using TOPS Data." Pp. 209-235 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No 86.

Hubbard, R. L., M. E. Marsden, J. V. Rachal, H. J. Harwood, E. R. Cavanaugh and H. M. Ginzburg. 1989. *Drug Abuse Treatment: A National Study of Effectiveness.* Chapel Hill, NC: University of North Carolina Press.

Hubbard, R. L. and M. T. French. 1991. "New Perspectives on the Benefit-Cost and Cost-Effectiveness of Drug Abuse Treatment." Pp. 94-113 in *Economic Costs, Cost-Effectiveness, Financing, and Community-Based Drug Treatment*, edited by W. S. Cartwright and J. M. Kaple. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 113.

Kleiman, M. R. 1997. "Drug Free or Unfree: To Get Heavy Users to Stay Clean, Link Parole and Probation to Abstinence." *Washington Post*, February 2:C3.

Knight, K., D.D. Simpson, I.R Chatham, and L.M Camacho, 1997. "An Assessment of Prison-Based Drug Treatment: Texas' in-prison therapeutic Community Program," *Journal of Offender Rehabilitation*, 24 (3/4), 75-100.

Leukefeld, C. G. and F. M. Tims. 1988a. "Compulsory Treatment: A Review of Findings." Pp. 236-251 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

Leukefeld, C. G. and F. M. Tims (Eds.). 1988b. *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

Leukefeld, C. G. and F. M. Tims. 1990. "Compulsory Treatment for Drug Abuse." *International Journal of the Addictions* 25:621-640.

Lipsey, M. W. 1990. *Design Sensitivity: Statistical Power for Experimental Research*. Newbury Park, CA: Sage Publications.

Lipton, D. S. 1995. "The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision." Presentation at the Conference on Criminal Justice Research and Evaluation. Washington, DC: National Institute of Justice.

Lockwood, D. and J. A. Inciardi. 1993. "CREST Outreach Center: A Work Release Iteration of the TC Model." Pp. 61-70 in *Innovative Strategies in the Treatment of Drug Abuse: Program Models and Strategies*, edited by J. A. Inciardi, F. Tims and B. Fletcher. Westport, CT: Greenwood Press.

MacKenzie, D. L. and C. Souryal. 1994. *Multi-Site Evaluation of Shock Incarceration*. Washington, DC: National Institute of Justice.

Martin, S. S. and J. A. Inciardi. 1996. "Case Management Outcomes for Drug Involved Offenders." Presentation at the American Society of Criminology Meeting in Chicago, IL.

Martin, S. S., J. A. Inciardi, F. R. Scarpitti and A. L. Nielsen, in press. "Case Management for Drug Involved Parolees: A Hard ACT to Follow." In *The Effectiveness of Innovative Approaches to Drug Abuse Treatment*, edited by J. A. Inciardi, F. M. Tims and B. W. Fletcher. Westport, CT: Greenwood Press.

Metja, C., P. J. Bokos, J. H. Mickenberg and E. M. Maslar. 1994a. "Case Management with Intravenous Drug Users: Implementation Issues and Strategies." Pp. 97-113 in *Drug Abuse Treatment: The Implementation of Innovative Approaches*, edited by B. W. Fletcher, J. A. Inciardi and A. M. Horton. Westport, CT: Greenwood Press.

Metja, C. L., P. J. Bokos, J. H. Mickenberg, E. M. Maslar, A. L. Hasson, V. Gill, Z. O'Keefe, S. S. Martin, H. Isenberg, J. A. Inciardi, D. Lockwood, R. C. Rapp, H. A. Siegal, J. H. Fisher and J. H. Wagner. 1994b. "Approaches to Case Management with Substance Abusing Populations." Pp. 301-319 in *Addictions: Concepts and Strategies for Treatment*, edited by J. A. Lewis. University Park, IL: Aspen Publishers, Inc.

Moore, S. T. 1990. "A Social Work Practice Model Of Case Management: The Case Management Grid." *Social Work* 35:444-448.

Moore, S. T. 1992. "Case Management and the Integration of Services: How Service Delivery Systems Shape Case Management." *Social Work* 37:418-423.

National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD). 1992. *State Resources and Services Related to Alcohol and Other Drug Abuse Problems.* Washington, DC: NASADAD.

Netting, E. F. 1992. "Case Management: Service or Symptoms?" *Social Work* 37:160-164.

Nurco, D. N., T. W. Kinlock, T. E. Hanlon and J. C. Ball. 1988. "Non-Narcotic Drug Use Over An Addiction Career: A Study of Heroin Addicts in Baltimore and New York City." *Comprehensive Psychiatry* 29:450-459.

Palmer, T. 1992. *Re-Emergence of Correctional Intervention.* Newbury Park, CA: Sage Publications.

Palmer, T. 1995. "Programmatic and Nonprogrammatic Aspects of Successful Intervention: New Directions for Research." *Crime and Delinquency* 41:100-131.

Parent, D., J. Byrne, V. Tsarfaty, L. Valade and J. Esselman. 1995. *Day Reporting Centers.* Washington, DC: National Institute of Justice.

Peters, R. H. 1993. "Drug Treatment in Jails and Detention Settings." Pp. 44-80 in *Drug Treatment and Criminal Justice*, edited by J. A. Inciardi. Newbury Park, CA: Sage Publications.

Peters, R. H., W. D. Kearns, M. R. Murrin and A. S. Dolente. 1992. "Effectiveness of In-Jail Substance Abuse Treatment: Evaluation Results from a National Demonstration Program." *American Jails* 6:98-104.

Peters, R. H. and R. L. May. 1992. "Drug Treatment Services in Jails." Pp. 38-50 in *Drug Abuse Treatment in Prisons and Jails*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 118.

Petersilia, J. 1989. "Implementing Randomized Experiments: Lessons From BJA's Intensive Supervision Project." *Evaluation Review* 13:435-458.

Petersilia, J. and S. Turner. 1992. "An Evaluation of Intensive Probation in California." *Journal of Criminal Law and Criminology* 82:610-658.

Petersilia, J. and S. Turner. 1993. *Evaluating Intensive Supervision Probation/Parole: Results of a Nationwide Experiment.* Washington, DC: National Institute of Justice.

Prendergast, M. L., M. D. Anglin and J. Wellisch. 1994. "Community-Based Treatment for Substance-Abusing Offenders: Principles and Practices of Effective Service Delivery." Presentation at This Works! Community Sanctions and Services for Special Offenders:

A Research Conference. International Association of Residential and Community Alternatives.

Schlesinger, M. and Dorwart, R. A. 1993. "Falling Between the Cracks: Failing National Strategies for the Treatment for Substance Abuse," Daedalus. 121 (3): 195-237.

Shwartz, M., G. Baker, K. P. Mulvey, A. Plough, 1997. "Improving Publicly Funded Substance Abuse Treatment: The Value of Case Management," *American Journal of Public Health*, 87(10): 1659-1664.

Siegal, H. A. and P. A. Cole. 1993. "Enhancing Criminal Justice Based Treatment Through the Application of the Intervention Approach." *Journal of Drug Issues* 23:131-142.

Siegal, H., R. C. Rapp, J. Fisher, P. Cole and J. H. Wagner. 1994. "Implementing Innovations in Drug Treatment: Case Management and Treatment Induction in the Enhanced Treatment Project." Pp. 131-143 in *Drug Abuse Treatment: The Implementation of Innovative Approaches*, edited by B. W. Fletcher, J. A. Inciardi and A. M. Horton. Westport, CT: Greenwood Press.

Siegert, F. A., & B. T. Yates. 1980. "Cost-Effectiveness of Individual In-Office, Individual In-Home, and Group Delivery Systems for Behavioral Child-Management." *Evaluation and the Health Professions*, 3:123-152.

Simpson, D. D. 1981. "Treatment for Drug Abuse: Follow-Up Outcomes and Length of Time Spent." *Archives General Psychiatry* 38:875-880.

Simpson, D. D., 1997. "Facts About Legal Offenders! Research Summary" Institute of Behavioral Research at Texas Christian University.

Simpson, D. D. 1998. "DATOS First-Wave Findings Released" Research Roundup, Vol 7(4):1-8. Institute of Behavioral Research at Texas Christian University.

Simpson, D. D. and S.B. Sells. 1982. "Effectiveness of Treatment for Drug Abuse: An Overview of the DARP Research Program." *Advances in Alcohol and Substance Abuse Treatment* 2:7-29.

Simpson, D. D., G.W. Joe, K. M. Broome, M. L Hiller, K. Knight, and G. A. Rowan-Szal. 1997a. "Program Diversity and Treatment Retention Rates in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11(4): 279-293.

Simpson, D. D. G. W. Joe, and B. S. Brown. 1997b. "Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11(4): 294-307.

Sullivan, W. P., D. J. Hartmann, D. Dillon and J. L. Wolk. 1994. "Implementing Case Management in Alcohol and Drug Treatment." *Families in Society* 75:67-73.

Swartz, J. A., Lurigio, A. J., and Slomka, S. A. 1996. "The Impact of IMPACT: An Assessment of the Effectiveness of a Jail-Based Treatment Program." *Crime and Delinquency* 42:553-573.

Swartz, J.A., 1994. "TASC—The Next 20 Years: Extending, Refining, and Assessing the Model," in J. A. Inciardi. Drug Treatment and Criminal Justice. Sage Criminal Justice Systems Annuals (27): Sage Publications.

Taxman, F. S. 1991. "Substance Abuse Treatment within the Criminal Justice System: An Analysis of Conflicting Models and Implications for the Criminal Justice System." *Perspectives* , Summer.

Taxman, F.S., 1994. "Results from Focus Groups with Defenders," in *Cornerstone* Vol 16(2),Summer,. Washington, D.C.: National Legal Aid and Defenders Association

Taxman, F. S. and J. M. Byrne. 1994. "Locating Absconders: Results from a Randomized Field Experiment." *Federal Probation* 58:13-23.

Taxman, F.S., and D. Spinner, 1997. *Jail Addiction Services (JAS) Demonstration Project in Montgomery County, MD: Jail and Community Based Substance Abuse Treatment Program Model.* University of Maryland, College Park.

Taxman, F. S., D. Lockwood, and D. Perez, 1996. *Washington/Baltimore HIDTA Case Studies: Results from 15 Months of Developing Seamless Systems.* University of Maryland, College Park.

Tims, F. M., B. W. Fletcher and R. L. Hubbard. 1991. "Treatment Outcomes for Drug Abuse Clients." Pp. 93-113 in *Improving Drug Abuse Treatment*, edited by R. W. Pickens, C. G. Leukefeld and C. R. Schuster. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 106.

Tims, F. M. and J. Ludford (Eds.). 1984. *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects.* Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 51.

Tonry, M. 1990. "Stated and Latent Functions of ISP." *Crime and Delinquency* 36:174-191.

Tonry, M. and R. Will. 1988. *Intermediate Sanctions.* Final Report to the National Institute of Justice. Castine, ME: Castine Research Corporation..

Visher, C. A. 1990. "Incorporating Drug Treatment in Criminal Sanctions." *NIJ Reports* 221:2-7.

Weinman, B. A. and D. Lockwood. 1993. "Inmate Drug Treatment Programming in the Federal Bureau of Prisons." Pp. 194-208 in *Drug Treatment and Criminal Justice*, edited by J. A. Inciardi. Newbury Park, CA: Sage Publications.

Wexler, H. K., G. P. Falkin and D. S. Lipton. 1990. "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment." *Criminal Justice and Behavior* 17:71-92.

Wexler, H. K., G. P. Falkin, D. S. Lipton and A. B. Rosenblum. 1992. "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment." Pp. 156-175 in *Drug Abuse Treatment in Prisons and Jails*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 118.

Wexler, H. K., D. S. Lipton and B. D. Johnson. 1988. *A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody.* Washington, DC, National Institute of Justice.

Williams, T and S. Spingarn, 1997. Personal Communication.

Washington/Baltimore HIDTA, 1997. *Annual Report to the Office of National Drug Control Policy.* University of Maryland, College Park.

Woodward, Bob, 1993. "Establishing and Maintaining the Policy Teams," in McGuarry, Peggy and M. Carter (eds) *Handbook for Policy Makers: Implementing Intermediate Sanctions.* National Institute of Corrections.

Mr. BARR. Thank you, Dr. Taxman. The gentleman from Wisconsin, Mr. Barrett, is recognized for 5 minutes.

Mr. BARRETT. Thank you, Mr. Chairman. I appreciate the time.

Mr. Hill, you talked about the need for testing in jails, and a question for you which pertains to the question I asked to the earlier panel: Do you think, as we look at the pie, we should be taking resources out of other areas and putting them into treatment; or do you think this calls for additional resources for treatment?

Mr. HILL. I think my testimony suggested that sometimes there is a misperception that when you say prisons, you mean jails too, and the legislation we often see doesn't include jails in the system. I remember in your previous question you asked if we should be reducing the moneys going into treatment, and the answer is no. I would certainly like to see that pie divided up a little bit and see more going into jail treatment programs because I think they are—they have a real good success rate.

Mr. BARRETT. Are we the ones that tie your hands, or do you find you are stymied in getting funds more at the State level? Is it the language within the Federal legislation when the money goes back to the States, or is it State policymakers who would rather put the money into State prisons?

Mr. HILL. Jails are generally not mentioned in the legislation, and that is something we are calling to your attention; that we need to do that, to specifically mention local jurisdictions in any legislation.

Mr. BARRETT. That's helpful for me to know that, because I was under the impression that jails were eligible for the dollars, and I would agree with you that might be a place.

Mr. HILL. I am not aware of any dollars being available to jails.

Mr. LIPTON. The localities are specifically referred to and they are set by legislation. However, the downside is the period of time which is required, which is 9 to 12 months' treatment; whereas these gentlemen on my right are both asking for 90 days' treatment, which would not be permissible under the current legislation.

Mr. BARRETT. Does your suggestion that we include jails include a component to that; that there would be aftercare? Again, I think Dr. Lipton and Dr. Taxman both believe that is something——

Mr. HILL. I think everyone who has testified today agrees we need aftercare. Absolutely, that should be part of any legislation; aftercare and some kind of measures of success, if we can come to some agreement as to what success of drug treatment programs are.

Mr. BARRETT. OK. Mr. Pratt, in order for jail-based treatment to work, what systems must be in place to continue treatment and achieve optimal results?

Mr. PRATT. Well, it originates in the courts. We persuaded the courts to send people into treatment for 90 days in Indianapolis and to mandate a followup, namely probation. And later on, the success of this was augmented by giving the GED to our people and job placement. So that now we have a jail specifically for addicts. It's completely used by community corrections for that purpose and the individuals get 90 days' treatment and then go into a work re-

lease center and into probation. Those are all things established now under community corrections.

I would add a word that the present legislation mandates at least 6 months' treatment. The reason we need new legislation is that people aren't in jail 6 months. Ninety days is much more the usual amount of time, and therefore the new legislation wants to reduce the jails from 6 months' to 90-days' treatment. That's one of its primary objectives.

Mr. BARRETT. Dr. Lipton.

Mr. LIPTON. The average length in jails, according to the AJA survey, is 79 days for sentenced inmates, which is obviously under 90. So what you need is not that you can't do treatment in that span of time; you can initiate treatment and you can link an individual into continuing care in the community, and that seems to be, in my judgment, the most effective use of jail and prison treatment; to start the program and then link it, but link it through the drug court pressure or other criminal justice pressure so that the individual on probation must continue the treatment for any span of time subsequent.

If you don't do that, you are wasting your resources, because all of the evidence points to the fact if you just do treatment up to the time of the release from prison, you will have very, very little impact.

Mr. BARRETT. Dr. Taxman, you wanted to add something.

Dr. TAXMAN. Yes, I wanted to add something. I think we all support the jail treatment and in providing services in the jail, and as Dr. Lipton mentioned, the question is what type of services and for how long. We have, as part of the HIDTA project, we have a pilot in one area that has a lot of promise, particularly with the short timeframes, which is this notion that you need to do treatment readiness.

We make very common assumptions that just because you tell someone they need to go to treatment or you offer a service that people are prepared to accept that service, and when I say "prepared to," I mean in terms of the mental and physical capabilities. There is a new model of treatment right now called treatment readiness which would work very well in the jail environment where you begin the preparation, the psychological and sociological preparation, and then through the continuous criminal justice leverage, give someone a guaranteed position in a community-based program outside of the jail.

Now, what we have found within the one piloted program which actually occurs in the Washington, DC area, is that most of the offenders needed residential substance abuse programs. They needed the structure, so the model that Washington, DC is using as part of the HIDTA program is the assessment orientation period for 30 days, followed by 90 days in a residential treatment program, followed by another 90 days in intensive outpatient program, and then aftercare services. So they have really got a system in place to move the client and use the leverage of the criminal justice system to retain that person in treatment.

Mr. BARRETT. To followup on that, as you are probably aware, there has been some criticism of the Baltimore-Washington HIDTA because it does have a treatment program. What is your best re-

sponse to the critics who say it's inappropriate to have a treatment component in the HIDTA?

Dr. TAXMAN. I think my best response is to ask the critics to contact some of the local police chiefs that participate in the executive committee, because I think one thing those local police—and when I say "local," I actually mean State and Federal and local police officers—would say is that they now understood what treatment is. When they came to the table, they didn't really understand that treatment is a demand reduction and they didn't see the benefits they could occur from treatment.

But if you talked to Commissioner Frazier, who is the police chief in Baltimore City, or if you talked to Chief John Farrell, who is the police chief from Prince Georges County, or some of the U.S. attorneys, you will find that what they will tell you is they now understand that treatment can actually reduce the criminal behavior and the police can rely upon that now as part of some of their strategy to reduce crime in the communities.

So my first suggestion would be to talk to, you know, the police chiefs.

The second part is this understanding that most people who came to the HIDTA executive committee came thinking treatment is soft and feely and it makes someone feel good. They didn't think about it as outcome based or crime reduction, but our data in the retention in treatment helped people understand there are benefits, particularly when they see the drug dealer who has a record of 25 prior arrests, which means they are on the street probably somewhere around 15 hours a day dealing drugs, and they are now actively involved in treatment programs within their communities, and then helping younger kids. Part of this effort is really to understand that treatment isn't the soft and feely image that a lot of people have; it really has a benefit to reduce crime.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. BARR. Thank you, Mr. Barrett.

I am becoming a little overwhelmed by statistics up here. I am left with a little unease with the statistics and, you know, we see it from some of the other witnesses in some other studies. There is one study here, and I think, it is from one of the witnesses on the first panel. This was included in their testimony; that according to the DATOS, only 5 to 10 percent of subjects in treatment stay in the programs. But yet one other figure that one of you all mentioned, I think, was 85-percent retention. Then I see some of the other testimony—I think included in your testimony, Mr. Pratt, you talk about—at the bottom of page 4, and the copy I have here is pretty close to illegible—it's either 30 or 50 percent of 25 percent. That's talking about recidivism rate, and I know mixing apples and oranges is easy to do with all of these statistics, but I am left with a little unease about the percentage rate, and I am not sure it's really fair to characterize it as just because people aren't indicted within any year or something after they get out, that that is really a fair measure of success.

I am a little bit concerned about that and I don't know if we can resolve it today. There are just so many statistics floating around, but maybe if you all could take it, Dr. Taxman and Dr. Lipton.

What are the actual figures? Is there any way of telling how successful these programs are?

Mr. LIPTON. There are about five national studies that have been conducted over the last 25, 30 years. There is a general level of consistency with respect to the positive outcomes, and these are the kinds of outcomes that the National Institute on Drug Abuse has been talking about over the years.

The differences that you are hearing are in part because we have been talking about criminal justice based programs done in prison, which have much higher retention rates than programs done in the community, where there is no compulsion for an individual to stay in a program. When an individual volunteers for treatment, they can turn around and walk out if they are in the community and not under any criminal justice leverage. Perhaps that underscores Dr. Satel's point about the use of leverage.

Do these programs work? And the question has to be asked in the framework of with what kinds of drugs, with what kind of people, over what span of time? And there are obviously a whole series of dimensions which we would need to attend to. And what we do know is that we have more success with heroin users using methadone programs, for example, than we have for heroin users using any other method.

We do know that outpatient programs do not produce the same level of outcome with very serious drug users that therapeutic communities do. And as we begin to look at subsets of the population, we see different kinds of outcomes, which accounts, perhaps, for some of the confusion that relates to differences in rates. But generally, the rates that are for each subgroup tend to be fairly consistent over time, and the results are that if you have no coercion, no leverage, and individuals, simply volunteers, walks into treatment and he is out in the community, you have very low retention. Very low.

Mr. BARR. Would that also make the figures themselves suspect if you are basically talking about self-reporting or relying on that amount for all these people that don't have a history of being truthful.

Mr. LIPTON. But the correctional drug abuse studies are all using biological specimens for determination as to their effectiveness, not simply self-reporting.

Mr. BARR. Dr. Taxman, if you could also maybe address briefly the question of funding. I mean, you all make a case for testing and treatment. In fact, the Federal Government does provide substantial sums of money. The difficulty we run into sometimes is trying to figure out exactly where the money is being used. The sum of $3.2 billion is a lot of money, at least by the standards of my constituents and probably most citizens in our country, yet that $3.2 billion, we have a very difficult time figuring out exactly where it's being used.

And perhaps some questions that we may have for some other panels, including perhaps some folks from HHS, would be where exactly is the money being used. If we only have a small number of programs, where is the rest of it being used?

So we are having somewhat of a difficulty from our standpoint tracking this money from an oversight perspective. And you all may have some questions about that as well.

Dr. Taxman.

Dr. TAXMAN. If you wouldn't mind, I would like to sort of go back and clarify one point. It was Dr. Satel who gave the retention rate issue of 20 percent, she was talking about those that volunteer for treatment. If you look at the studies on program completion which are not self-report, they are program data from the programs themselves, they are very low for the volunteers that Dr. Lipton talked about. But on average, the retention rates are about 50 percent for criminal justice clients with these clients doing better than volunteers, if you look at program data records.

This leads to the question you have asked more directly, which has to do about funding and your difficulty of trying to find out how many programs are out there. I think part of the issue is that the majority of funds are block grant dollars that are given to States and the States then give them to the localities to put in place programs. Unfortunately, as was noted, there used to be a client data system.

Mr. BARR. I think that is only about a third of $3.2 billion, so that still leaves sort of $2.2 billion that we can't really figure out where it goes to.

Dr. TAXMAN. There are discretionary programs that come out of some of the OJP programs.

Mr. BARR. My only point, and it is not critical of you all, maybe you all can help us try and track where the money—I mean, there is a substantial amount of money that has been appropriated out there for precisely the kind of programs you all are advocating.

Dr. TAXMAN. And I think if you look, and I can only speak because I have looked at how the block grants run through different States, is that the funds get used for administrative costs instead of going directly into programs.

My only concern about the block grants, and even some of these discretionary grants, is having a reporting system in place that deals with program retention rates so you can use that to really gauge, performance measures about programs.

But I think, you know, some surveys of different States begin to ask what treatment programs are out there and who funds them, most of these programs have multiple funding sources, and so they are always trying to scramble to get programs.

Mr. BARR. Thank you.

Mr. Barrett, would you have any objection? I have a couple of followup questions.

Mr. Hill, I guess I would direct this to you because of your particular background, but maybe Mr. Pratt also. Most inmates, either in jails or prisons, are there pursuant to State criminal offenses, not Federal. Are you aware of any law—of any State that prohibits, by law, drug testing of inmates of jails or prison facilities, or any State that prohibits drug treatment?

Mr. HILL. None that I am aware of, no.

Mr. BARR. I don't think that there are, and therefore it seems that really the primary focus really ought to be with State officials. In your experience, where does the opposition to these sorts of pro-

grams at the State level come from, the use of moneys for testing and treatment? Is it essentially a fiscal objection; is it a lack of interest on the parts of State governments to tackle this problem and provide for drug treatment and testing at State facilities or county facilities? Where is the main problem?

Mr. HILL. Are you speaking in terms of Federal funding?

Mr. BARR. No, State. Since the primary problem, really, given the number of inmates being primarily those who have committed State offenses and are in State or some county holding facilities, it seems to me the first place we ought to look to address the problem of why aren't there more treatment programs should be State governments. And is there something we need to be aware of why State governments are opposing or don't seem to be addressing the problem?

Mr. HILL. I would believe it's a matter of dollars, that they simply don't believe they have the number of dollars. In Pennsylvania currently, most county jails, their populations are about 28 to 30 percent State prisoners, those who could be serving their time in State prisons, and we are not receiving funding for that. So I don't see the impetus coming from the States to fund localities. I don't think we are seeing that in government today.

Mr. BARR. And no matter how much we do in the Federal Government, there is only so much of a problem that we could tackle.

Mr. HILL. Well, we call the Feds Uncle Sam because he has all the money. We tax everybody and the States try to come in and get some of that money, so we look to "Big Daddy" to give us the money, I guess.

Mr. BARR. Well, I understand what you are saying and I know you are only being partially facetious; but the fact of the matter is that this really is primarily a problem that ought to be tackled by the States. I am not aware whether there are groups out there that are really addressing this at the State level. That would be very helpful to us at the Federal levels, and this should not be the tail wagging the dog. This might be an area where a great deal more focus by advocates and experts such as yourself could be of help in urging State legislatures to address this issue.

Mr. Pratt, did you have any thoughts on that before I ask Mr. Barrett if he has any additional questions?

Mr. PRATT. Well, one of the things that have influenced that, of course, is the provision of the funding for drug-alcohol treatment in the 1994 act that allowed the States to give treatment in the State penitentiaries, and 15 percent of that money was to have gone for the county jails. And because of the factor we discussed earlier, that they mandated 6 months' treatment, the county jails didn't get the money. We found it very difficult, in Indianapolis, to get money for random drug treatment. We are still battling that battle, a very good use of the funding.

I conclude, too, by saying that your question about the validity of the effectiveness of this treatment needs to be clarified. Our five studies show an average 54 percent of people not coming back to jail 2 years after treatment. That's a very hard figure. The reason I say 25 percent has to be subtracted from that figure to be really accurate is because the Department of Justice shows that 25 percent of all persons do not come back to prison at all. You are get-

ting a 25 percent, you might say, natural cut in recidivism. So the most we can attribute to the effectiveness of this program is about 25 to 27 percent.

As Dr. Lipton said earlier, that's a tremendous figure. It's one of the greatest figures in the reduction of crime that we know about.

Mr. BARR. And another audience to which you might address those particular points, in addition to State governments, is the Secretary of HHS, because they were the ones that have control over the lion's share of our $3.2 billion which was appropriated in the current fiscal year. So that really ought to be another audience, not just those of us up here.

We can't micromanage, or at least we don't want to be in a position of managing HHS or any other departments. But again, if you all as experts can bring that to bear in the department and help us direct those moneys to these sorts of programs, we might see more of an impact.

Let me just ask Mr. Barrett if he had any final questions.

Mr. BARRETT. I have talked a lot today or made reference to the problem of resource allocation, and one of the things this Congress has done is pass legislation that sends money back to the States for prison construction, something that is very popular, obviously, among people who feel that people who commit crimes should be locked up for long periods of time.

My question for each of you is, would you support—and there is legislation pending—do you think it's a good idea to allow the States to use some of that money for drug treatment, which would mean they would not be using it for prison construction, but it would be used for drug treatment in prisons or in jails, obviously, something that some of you favor—would that be something you think would be prudent to your health?

Mr. HILL. I think it would be prudent if we put some caveats on it, that we want to know that the treatment is effective; we want to agree on what are the measures of success. I don't think I have heard any agreement on what the measure of success is to any of the programs. I don't think we should be investing any money into a program unless we know what the outcomes should be and that we have some clear measures of that, so that we know we are getting the bang for our bucks.

Mr. BARRETT. Mr. Pratt.

Mr. PRATT. About a year ago, I went to both Members of the House and the Senate with a very similar request to the one that you are considering, and I got very negative results. I fell back upon the promotion of the legislation I described—where we would use a percentage of the State funding in the 1994 act for the county jails—that mandates 10 percent of that. That was about the best response I could get from the Senate and the House.

Mr. BARRETT. Dr. Lipton.

Mr. LIPTON. Yes. The answer I give you is that unequivocal testing, sanctions and treatment, use of that money clearly is necessary and needed. However, the real important caveat is if we apply treatment on a much broader scale, we are going to run out of trained people like that. If we start doing treatment with untrained people, our success rates which we have been talking about are going to go like that.

So we need to couple the investment in treatment, however, out of whatever source it may come, with improved training, scholarships, internships, programs that would sponsor forensic psychology departments to produce trained individuals for these kinds of programs.

Mr. BARRETT. I understand. Dr. Taxman.

Dr. TAXMAN. I agree with Dr. Lipton, unequivocally, yes, and I would also hope you would think about imposing or using some of the RSAT criteria in terms of having a timeframe for these treatment programs, because I think that it is very beneficial to get the types of outcomes that everyone desires. Also by loosening the requirements to allow for RSAT to pay for some of the services in the community so we can put in place as part of systems of care, and also using that for the supervision component.

That is one part, although, you know, I understand Mr. Barrett's point that this is not typically a Federal responsibility, it is a State and local responsibility. It is an area in which there is a real need to focus in, because we can't supervise offenders in treatment when you have a probation agent that has 200 offenders on their caseloads.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. BARR. I would like to thank the distinguished ranking member and I would like to thank members of the panel. We do need to conclude.

If there is additional material, I fully anticipate that we will be holding additional hearings on these matters, and if there are additional materials you would like us to consider or additional questions you believe we ought to be posing to other witnesses, for example, with Government agencies, please submit that material to the subcommittee chairman, Mr. Hastert.

Again, whatever materials you all have submitted today will be included in full in the record. We appreciate very much your time and expertise. We are hereby adjourned.

[Whereupon, at 1:14 p.m., the subcommittee was adjourned.]

○