

PROPERTY OF  
National Criminal Justice Reference Service (NCJRS)  
Box 6000  
Rockville, MD 20849-6000

183810

**-WORKING DOCUMENT-**

## **DRUGS, ALCOHOL ABUSE, AND THE CRIMINAL OFFENDER**

**BREAKING THE CYCLE--  
BREAKING FREE OF THE CYCLE:  
POLICY FOR COMMUNITY AND INSTITUTIONAL  
INTERVENTIONS  
TO SAFEGUARD PUBLIC SAFETY  
AND RESTORE PUBLIC HEALTH**



**FOR DISCUSSION AT THE NATIONAL ASSEMBLY ON DRUGS,  
ALCOHOL ABUSE, AND THE CRIMINAL OFFENDER  
DECEMBER 7-9, 1999**

## CONTENTS

<b>I. MOVING FROM POLICY TO ACTION</b>	<b>1</b>
<b>A. INTRODUCTION</b>	<b>1</b>
<b>B. POLICY STATEMENT</b>	<b>3</b>
<b>C. GETTING STARTED: A NINE-POINT ACTION CHECKLIST</b>	<b>5</b>
<b>II. IMPLEMENTING INTERVENTIONS</b>	<b>9</b>
<b>A. Community-based Interventions</b>	<b>9</b>
<b>B. Institutional Interventions</b>	<b>11</b>
<b>C. Community Interventions and Offender Re-entry</b>	<b>12</b>
<b>III. BACKGROUND AND DISCUSSION</b>	<b>15</b>
<b>A. THE NEED TO RECONSIDER EXISTING POLICY</b>	<b>15</b>
<b>B. A BRIEF OVERVIEW OF EXISTING KNOWLEDGE</b>	<b>23</b>
<b>C. GUIDING PRINCIPLES FOR POLICY</b>	<b>25</b>
<b>1. Confronting the Myths</b>	<b>25</b>
<b>2. Applying What Science and Experience Have Taught</b>	<b>26</b>
<b>D. RESEARCH AND TECHNICAL ASSISTANCE PRIORITIES</b>	<b>29</b>
<b>E. PERFORMANCE MEASURES OF EFFECTIVENESS</b>	<b>31</b>
<b>F. ACKNOWLEDGEMENTS, BIBLIOGRAPHY, AND ENDNOTES</b>	<b>33</b>

## **I. MOVING FROM POLICY TO ACTION**

### **A. INTRODUCTION**

Substance abuse leads hundreds of thousands of people into the criminal and juvenile justice systems each year, many in need of treatment. There have been many creative responses to the challenges presented by the growing number of substance-disordered offenders -- TASC programs, boot camps, and drug courts to name a few. Unfortunately, the tendency of the justice systems to focus on individual programs, no matter how good, results in episodic treatment of small percentages of the population in need. TASC programs and drug courts are operating effectively, but in only a small fraction of the counties in the United States. Systemic policies, not merely programs, must become the focus for efforts to link treatment with the justice systems. Substance disorders and related crime put both public safety and public health at risk, and require a policy that combines both justice and health expertise and interventions.

In March of 1998, scholars, policy makers, and practitioners from around the country met with ONDCP and the Departments of Justice (DOJ) and Health and Human Services (HHS), to focus on systemic policy. This consensus meeting took stock of existing knowledge regarding drug treatment and the justice system, probing scientific research and clinical experience to determine what is known with reasonable confidence. The participants found that a great deal is known, but also found that what is being done is often not consistent with what is known.

To help bridge the gap between research and action, ONDCP crafted a draft policy statement reflecting the state of established knowledge and circulated it, first among Federal agencies and then among major stakeholder organizations. On June 25, 1999, forty stakeholder organizations met in Washington to advise DOJ, HHS, and ONDCP on the essential content of national policy addressing drug treatment and the justice systems. These, and other, organizations have provided a number of helpful suggestions and this revised statement contains improvements made in response to comments received.

**NOTE:** New or technical terms are generally defined at the point where they are used in this statement. One term, in particular, warrants specific mention. The term "disorder" is used throughout the statement in its clinical sense. It is a broad term that encompasses abuse and dependence, which are both addressed as disorders by clinical experts.

## **B. POLICY STATEMENT**

Working in concert, justice and public health agencies can establish a continuum of accountability and treatment for drug and alcohol abusing and dependent juvenile and adult offenders. The following statement addresses the content of policy to establish such a continuum.

*The criminal and juvenile justice systems should operate – in concert with other service systems - as a series of opportunities for intervention with drug and alcohol disordered offenders. Interventions should be carried out in a systematic manner and at the earliest possible opportunity:*

- *To prevent entry into the criminal/juvenile justice system for those who can be safely diverted to community social service systems.*
- *To limit penetration into the criminal/juvenile justice system for adult and juvenile nonviolent offenders through community justice interventions in concert with other social service systems.*
- *To intervene with those who must be incarcerated or securely confined, through appropriate treatment and supervision, both during and after the period of confinement.*

## **C. GETTING STARTED: A NINE-POINT ACTION CHECKLIST**

*Improving public safety and public health requires systematic interventions to bring about long-term change in the substance abusing and criminal behaviors of offenders.* Treatment must be a priority of the justice system and incorporated into the routine practices and decisions of justice officials. More than simple coordination is required for effective work with service providers that often adhere to goals other than public safety (e.g., the provision of healing services to clients). Policies and operational procedures must cross organizational boundaries to make treatment decisions a critical element of justice decisions. The following checklist is offered as a quick reference for those communities that intend to move beyond coordination of programs to full collaboration among community agencies with integrated decisions and services.

- 1. SET THE STAGE.** Recognize substance abuse as a public health and public safety problem that requires the collective efforts of the health and justice communities working in an integrated fashion. The two systems must adopt a policy requiring public health services to be intertwined with justice services to change the behavior of adult and juvenile offenders.
- 2. FIRST THINGS FIRST.** Identify areas where collaboration will result in long-term benefits. It is common practice for treatment agencies to make decisions based on clinical criteria, while justice agencies make decisions based on security criteria. Many of these decisions have consequences for both systems as well as for the community and the offender. Yet decisions are seldom made jointly and decision information is often not shared in a timely manner. Operational procedures can and should be developed to ensure joint decision making in areas that impact both the health and justice systems: assessment, treatment placement, treatment monitoring protocols, drug testing protocols, and treatment discharge. Joint decision making in these areas would foster long-term behavior change for adult and juvenile offenders and reduce threats to public safety and health.
- 3. TREATMENT'S CONTRIBUTION.** Recognize treatment as crime control. Treatment is not an ancillary service. Rather, treatment is employed to reduce recidivism, including substance seeking and abusing behaviors. Such recognition by public health, justice, and the general public will focus attention on expected outcomes (e.g., law-abiding citizens who are managing their substance abuse disorder). It will also encourage public health officials to acknowledge that treating the offender is a major community priority that may require changes in the existing delivery system.
- 4. THE IMPORTANCE OF ASSESSMENT.** Employ assessment protocols that integrate substance abuse and criminal justice risk factors. Too often the justice and public health systems do separate assessments. Few states have mechanisms that allow

the public health system to access justice records, requiring them to rely on offender self-report. Thus, treatment and justice decisions are often made without having both justice and clinical assessments. States should develop an integrated assessment of criminal risk and substance abuse severity, which also addresses mental health, primary health, and social services needs, to guide treatment and justice decisions.

**5. RATIONAL PLACEMENT. Adhere strictly to placement based on an integrated assessment of risk and severity of substance-related disorders.** Often offenders are placed in the program with the first available slot instead of matching the service needs of the offender with the service provision of a program. Treatment placement protocols are needed to place offenders into the appropriate treatment programs, offering the treatment and justice monitoring suited to the risk level of the offender.

**6. INDIVIDUAL TREATMENT PLANS.** Employ the integrated assessment to develop an individual treatment plan for each offender. Many offenders will present mental and primary health problems and life skills deficits, in addition to substance disorders and criminal thinking disorders. The individual treatment plan should serve as the blueprint for coordinating services and supervision, as well as a basis for assessing offender progress and program performance.

**7. RIGOROUS CASE MANAGEMENT.** Manage offenders in treatment with testing, supervision, sanctions, and rewards. Adult and juvenile offenders in treatment must be closely supervised and their cases tightly managed. Supervision and treatment components must function as a team for case management where decisions regarding level of care, testing, supervision, and sanctions/rewards are made together. The power of treatment and justice working together is the consistent message to the offender, i.e., substance abusing and criminal behavior are no longer tolerated and the offender must change his/her behavior. Drug testing is an important offender management tool and should be used throughout the treatment process. Both treatment and justice agencies should have timely access to drug testing information as a routine operational procedure tied to sanctions and rewards, which in turn must be swift and certain, to reinforce the message of accountability.

**8. STRUCTURED ACCOUNTABILITY.** Be fair and predictable in delivering sanctions and rewards. Offenders respond to situations that they believe are fair and just, and to sanctions and rewards that are uniformly applied. To be effective, sanctions must be administered by treatment and justice staff in adherence to an adopted sanction protocol, delivered shortly after the infraction and with predictable certainty, and graduated to fit the infraction. Rewards should be provided in a similar manner, to complement sanctions, and tied to behavioral objectives achieved by the offender.

**9. FOLLOW THROUGH.** Extend the impact of treatment by providing a continuum of supervision and support. Many offenders have a significant history of substance abuse and criminal activity and require treatment programs of significant duration. Such programs can be accomplished in a cost-effective manner, by providing different levels of treatment intensity as required. It is critical that adult and juvenile offenders receiving treatment in correctional or other secure facilities continue with treatment and supervision in the community. Rigorous transitional and follow up services will maximize the recidivism reduction potential of treatment.

## **II. IMPLEMENTING INTERVENTIONS - A DETAILED CHECKLIST**

The following set of recommended actions is organized and presented in checklist form to reflect the stages of criminal and juvenile justice involvement, starting with arrest, as opportunities for intervention. ONDCP's "Breaking the Cycle" initiative is now pursuing these actions with adult offenders in three sites and with juveniles in one.

SAMHSA/CSAT's criminal and juvenile justice treatment networks are using a similar approach in four adult and three juvenile sites. A collaborative approach, spanning both the division and separation of powers, will be essential to a national effort; however, small steps taken now can have an immediate effect.

**NOTE:** References to the threat of incarceration as a means to foster treatment compliance are not intended to suggest that an offender who would not otherwise warrant incarceration would be subject to incarceration for failure to comply with a treatment program. Furthermore, the critical information sharing that is called for throughout the system is subject to existing Federal law and regulations addressing confidentiality.

### **A. Community-based Interventions**

#### ***1. Diversion/Pretrial Release***

- At the time of arrest, all adult and juvenile arrestees should be screened for drug and alcohol problems and assessed regarding the risk they present to the community. Public defenders should be allowed the opportunity to participate in diversion deliberations.
- All who test positive, and are eligible for diversion or pretrial release, should have their release conditioned on compliance with a regime of drug testing.
- All who test positive during the period of release should face graduated sanctions.
- All who test positive should be assessed to determine the need for and appropriate level of drug treatment.
- Those assessed to be in need of drug treatment, and who are eligible for diversion or pretrial release, should be referred to appropriate treatment and will have their release conditioned on compliance with the treatment plan.
- The target caseload for pretrial officers supervising drug or alcohol abusing or dependent offenders should not exceed 25, to allow for intensive supervision and frequent testing.



- All who fail to comply with treatment during the period of release should face graduated sanctions, culminating in pretrial detention for releasees unable or unwilling to comply.
- Eligible offenders who comply with the conditions of release should be given the opportunity to continue on release contingent on continued compliance.
- Eligible adult and juvenile offenders who continue in compliance with conditions, including those who successfully complete treatment, should have the charges against them dismissed or adjourned in contemplation of dismissal (i.e., compliant first offenders will have no criminal record, other offenders no additional record of conviction or adjudication).
- Information gathered during the pretrial/pre-adjudication process should be made available for those defendants/offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

## ***2. Pretrial Detention***

- Those detained and assessed to be in need of drug treatment should be placed in a treatment program and compliance with the treatment plan will be part of the case disposition for those convicted/adjudicated.
- Information gathered during the pretrial process should be made available for those defendants/offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

## ***3. Sentencing***

- For all adults and juveniles that are tried/adjudicated and found guilty, a pre-sentence investigation/report should be completed.
- The sentencing/disposition judge should incorporate information from pretrial activity (treatment need, type of treatment initiated, compliance with testing and treatment conditions, compliance with other conditions) into the sentencing process, and include compliance with testing and treatment requirements as a part of the sentence. Post-release supervision should be part of any sentence to incarceration for drug and alcohol abusing and dependent adult and juvenile offenders.

- Information gathered during the trial and sentencing process should be made available for those offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

#### ***4. Community Corrections***

- Those sentenced to probation, with a condition of compliance with drug treatment during probation, should be placed in an appropriate treatment program (those in pretrial release should continue in the program started during pretrial; others should continue in a program consistent with the one started during pretrial) and compliance with testing and treatment program conditions should be a primary consideration in the release from probation decision.
- The target caseload for probation, parole, and other community corrections officers supervising drug or alcohol abusing or dependent offenders should not exceed 25, to allow for intensive supervision and frequent testing.
- Contacts with the probation or other community corrections officer should be frequent and offenders who fail to comply with treatment conditions should face graduated sanctions, culminating in appropriate detention for those unable to comply (e.g., short- or long-term incarceration, residential treatment, institutional training school placement).
- Information gathered during the community corrections period should be maintained to follow those offenders that remain in or are returned to the criminal and juvenile justice systems.

### **B. Institutional Interventions**

#### ***1. Jail/Detention***

- Jails/Detention facilities should establish necessary procedures to maintain a drug-free environment, including testing for inmates and detection procedures for others. Inmates who test positive should face graduated sanctions, culminating in an extended period of detention as a result of loss of good time credit.
- Those sentenced, with a condition of compliance with drug treatment during and after incarceration, should be placed in an appropriate treatment program (when practicable, those in pretrial detention will continue in the program started during pretrial/pre-adjudication; others will continue in a program consistent with the one

started during pretrial) and compliance with treatment program conditions should be a primary consideration in release decisions and in post incarceration conditions.

- Information gathered during the jail/detention period should be made available for those offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

## **2. Prison/Juvenile Corrections**

- Prisons/juvenile corrections should establish necessary procedures to maintain a drug-free environment, including testing for inmates and detection procedures for others. Inmates that test positive should face graduated sanctions, including the loss of good time credit, which can result in an extended period of incarceration.
- Those sentenced to incarceration, with a condition of compliance with drug treatment during and after incarceration, should be placed in a treatment program consistent with programs provided earlier, unless further assessment indicates the need for an adjustment. Compliance with treatment program conditions should be a primary consideration in release decisions and in post incarceration conditions.
- Eligible adult and juvenile offenders that successfully complete a program of treatment and rehabilitation within the institution should be considered for early release to transitional and community follow up treatment.
- Planning for transition of adult and juvenile offenders back to the community should be accomplished well in advance of release and should include: clear conditions for release with clear sanctions for noncompliance; assurance of continuing, compatible treatment in the community; access to needed vocational and social services, and an established regime of testing and supervision.
- Information gathered during the incarceration period should follow offenders through the remaining justice processes (i.e. made available to inform each subsequent decision).

## **C. Community Interventions and Offender Re-entry**

### **1. Post Incarceration**

- For adult and juvenile offenders subject to post-release supervision, compliance with treatment and testing conditions should continue for a minimum of six months after return to the community. Those who test positive or otherwise fail to comply with

testing and treatment conditions will face graduated sanctions, culminating in re-incarceration for those unable to comply with the conditions of release.

- Information gathered during post-incarceration supervision should be maintained to follow offenders through any subsequent decisions.

### **III. BACKGROUND AND DISCUSSION**

#### **A. THE NEED TO RECONSIDER EXISTING POLICY**

***Existing policy relies heavily on incarceration, notably so for drug offenders.***

Today, incarceration is a common result of conviction, sentences are longer, and probation and parole revocations are on the rise. Prisons and jails hold more than 1.8 million persons.<sup>1</sup> Between 1986 and 1997, time actually served under Federal sentences nearly doubled - from 14.5 months to 28.8 months. The increase is mostly explained by sentences served for drug offenses, weapons offenses, and immigration offenses. For Federal drug offenders, time served more than doubled - from 20.4 months to 42.5 months, while increases for violent and for property crime were nine and one percent, respectively.<sup>2</sup> At the state level parole violators constituted 35 percent of 1996 prison admissions, compared to 18 percent in 1980.<sup>3</sup> As a result in 1998, despite significant prison construction, State prisons were operating at between 13 and 22 percent above capacity, while Federal prisons were operating at 27 percent above capacity.<sup>4</sup> Crowded facilities have less room for needed programs.

***Incarceration is an important but limited element in the maintenance of social order.***

By itself, it can incapacitate violent offenders for a period of time (e.g., an average of 53.3 months in the Federal system in 1997).<sup>5</sup> For other offenders, however, incarceration alone is a limited response. It is costly, causes harm when improperly employed, and is not an effective alternative to treatment for offenders with mental health and substance disorders.

Community health and good order require a periodic assessment of the policies that determine which offenders are to remain in the community, which are to be incarcerated, and which interventions are to be employed in each setting.

***Incarceration is a costly approach.*** In 1996, states and localities spent over \$27 billion in corrections, over \$21 billion for prison operations alone. The average annual cost per inmate was \$20,142, ranging from a low of \$8,000 to a high of \$37,800. For the Federal system annual cost per inmate was \$23,500.<sup>6</sup> By comparison, probation and parole costs, in 1997, ranged from \$1,110 per year for regular supervision, to \$3,470 for intensive supervision, and to \$3,630 for electronic supervision. Cost variation is explained primarily by caseload. The average caseload for regular probation was 175, for regular parole 69. The average caseloads for intensive supervision probation and parole were 34 and 29, respectively; for electronic supervision 20 and 18.<sup>7</sup>

There are also indirect costs of incarceration. Incarceration is not only costly in itself; it drains resources from other criminal justice activities and ultimately from other social services. Further, there are social costs including tax and welfare revenue and

costs to families and communities of having a relative and resident removed. In the final analysis, cost-conscious public safety may call for less emphasis on retribution and more on incapacitation when deciding whom to imprison.

***By comparison, treatment is inexpensive.*** Using the Federal Bureau of Prisons as a representative institutional program, the cost of residential and transitional treatment and services is estimated at \$3,000 per inmate. Generally accepted estimates of annual treatment costs per person in the community are: regular outpatient, \$1,800; intensive outpatient, \$2,500; short term residential, \$4,400; and long term residential, \$6,800. Thus, combining the most expensive community supervision with the most expensive treatment yields an estimated average cost of \$10,430 per person per year compared to \$20,142 for incarceration alone, and \$23,142 for incarceration combined with treatment and transitional services.<sup>8</sup>

***Incarceration alone will not make communities safe.*** The contribution of incarceration alone to public safety is limited. Prisons/detention centers are a temporary response that addresses a third of the offenders under criminal justice supervision. The remaining 3.7 million offenders are in community programs and each year five hundred thousand people return to their communities from state prisons.<sup>9</sup> Furthermore, while it is likely that policy favoring incarceration has made some contribution to the decrease in violent crime over the last six years, it is also likely that the exploding prison population now includes offenders who could be managed and treated safely and effectively in the community (perhaps eight percent or more "drug only offenders," according to the Manhattan Institute).<sup>10</sup> Studies by Federal agencies and private organizations, including the RAND Corporation, the Manhattan Institute, and the National Center on Addiction and Substance Abuse at Columbia University (CASA), suggest that we need to do a better job of deciding whom to put behind bars and what to do with them while they are there.

***Incarceration alone will not change the behavior of substance abusing offenders.*** Drug-dependent offenders are responsible for a disproportionate amount of crime. During periods of heavy or addicted use, the frequency and severity of criminal activity rises dramatically. A survey of chronic drug users not in treatment in 1992 found that over half were involved in illegal activity, with 10 percent deriving income solely from illegal sources. Fortunately, entry into drug treatment has been shown to have an immediate impact on the levels of drug use and associated crime, and retention in drug treatment to have a significant impact. About 5.5 million people are on probation, in jail or prison, or on parole. And, while reliable, consistent data on treatment needs among criminal justice populations are sparse, as are data on the quality of programs being offered, a very conservative estimate would be that over a million offenders under criminal justice supervision need, and are not getting, drug treatment.<sup>11</sup> Returning these offenders to their communities, without treatment intervention, is a significant missed opportunity and a threat to public safety.

***Treatment can change the behavior of offenders, including incarcerated populations.*** Major longitudinal studies have repeatedly shown that drug use and criminal activity decline upon entry into treatment and remain below pre-treatment levels for up to six years. 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.

State evaluations have yielded similar results. Colorado followed up on treatment graduates and found that, among those who had been arrested in the two years prior to treatment, 80 percent had no arrests. Maine followed treatment graduates for a year and found that 78 percent had no arrests. Washington found that, after four 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 one-year follow up of treatment graduates, that 80 percent had no arrests.<sup>12</sup> The interrelationship of public safety and public health is evident at each stage of the justice system.

***Community service resources have been allowed to erode.*** The Drug Abuse Treatment Outcome Study (DATOS) found fewer social services available for those in treatment than had been the case in earlier national studies.<sup>13</sup> Excesses in managed care have restricted access to the services available and shifted costs to the public sector. The inability of eroded community services to intervene effectively brings many to the criminal or juvenile justice system for their treatment. This is especially so in rural areas where, for example, Native Americans have an arrest rate for alcohol violations more than double the national rate. On any given day, our jails house more than 25,000 people suffering from both mental illness and substance abuse disorders. Over 300,000 are affected by one or the other disability. Over half of the inmates in state and Federal prisons have a mental health or substance disorder – nearly 700,000. Over 200,000 suffer from the most serious mental illnesses.<sup>14</sup>

***Community justice resources have deteriorated.*** Community corrections has experienced an erosion of infrastructure similar to that of other community services. From 1980 to 1994, the probation population increased by the same 213 percent as the prison population<sup>15</sup>, yet sufficient resources have not been allocated to keep caseloads manageable. In a majority of cases, offenders mandated to treatment are assigned to parole, probation, or some other form of community supervision. Community supervision

includes a range of governmental activities designed to punish, manage, control, and rehabilitate offenders in the communities where they live. Parole and probation officers often work with private agency service providers to supervise offenders in community settings and change negative behaviors and habits. Community supervision allows offenders to maintain work and family ties and to compensate victims and communities for costs associated with their crimes. For such programs to be effective, they must be well coordinated, adequately staffed, and supported with a strong intergovernmental infrastructure. Supervision is impossible with caseloads in the hundreds, very difficult with caseloads over 30. Given probation caseloads that average 175 and range to 900, surveillance has replaced supervision in many communities.<sup>16</sup>

***Local political leadership is not consistently called upon.*** Agency decision-makers at different levels of government and in different branches sometimes fail to take the views of local political leadership into account and thus deny themselves the systems overview necessary for effective implementation.

***State and local discretion is undermined.*** Existing policies are sometimes piecemeal and contradictory, and rely heavily on incarceration as a means of retribution, rather than community justice as a means of rehabilitation, deterrence, and incapacitation. Mandatory minimums constrain local discretion, often replacing cooperative state and local relationships with pressures toward incarceration. For example, a local decision to imprison an offender may shift the cost from the county to the state. Similarly, in some jurisdictions, a probation or parole officer's decision to revoke shifts the caseload from community corrections to the state. Many legislatures prohibit numerous possessions and activities for inmates, thus depriving correctional administrators of powerful motivational tools. Prison and jail administrators should be allowed the flexibility to employ a broad range of sanctions and incentives to discipline infractions, motivate change, recognize progress, and enhance staff safety.

***Actions are too often assessed in terms of intended rather than actual consequences.*** Some current policies have unforeseen, long-term, negative consequences. For example, decisions to prosecute and convict -- rather than divert -- nonviolent youthful offenders leave many young people with a criminal record that will present a lifelong obstacle to employment and could contribute to the growth of a permanent underclass. For the juvenile justice system decisions to adjudicate and commit-- rather than divert -- nonviolent youthful offenders have similar consequences. This is of particular concern given the tendency in the 1980's and 1990's to treat juvenile offenders like criminals. These changes have manifested in laws that facilitate the transfer of juvenile offenders to criminal courts, expand sentencing authority, and modify or remove traditional juvenile court confidentiality provisions.



***Mental health, primary health, race and ethnicity, age, and gender are often not adequately addressed by existing interventions.*** Many juvenile and adult offenders who abuse or are dependent on drugs and alcohol also have co-occurring mental disorders and primary health care needs. For example, approximately 13% of the prison population have both a serious mental illness and a co-occurring substance abuse disorder<sup>17</sup>, and many others have or are at risk for HIV/AIDS and other infectious diseases. To be maximally effective, treatment must address these co-occurring health conditions, must be appropriate to the age and gender of the offender, and must be appropriate to the offender's race and ethnic heritage. Treatment should also involve the offender's family, when possible. The children of substance abusing offenders are at higher risk for substance abuse and criminal behavior themselves. Therefore, treatment that involves the offender's family can help to break the intergenerational cycle of substance abuse and crime.

***The juvenile justice system is not fully recognized as a cost-effective opportunity to prevent the cycle of substance abuse and crime.*** The juvenile justice system was specifically developed to respond to young offenders differently than the adult justice system. Since its inception, the primary goal of juvenile justice has been rehabilitation rather than punishment, focusing on youth in the context of the family. However, despite research in recent years that supports the wisdom of maintaining a separate juvenile justice system, a departure from this approach has begun. Forty-six states have adopted laws permitting some juveniles to be tried and sentenced as adults. Nineteen young offenders have been executed since 1990. Seventy are on death row.<sup>18</sup>

The relationship between youth drug use and crime has been established but is complicated by the fact that youth are risk takers and experimenters by nature, and will sometimes engage in behaviors that are illegal. From a developmental perspective, adolescence is a major transitional phase that is defined by significant physical development coupled with increases in aggressive behavior, increased conflicts with parents and other authority figures, and an orientation away from family and toward peers and experimentation. Recent brain research strongly suggests that youth simply do not have the same capabilities as adults for impulse control, prioritization, and planning. They are still developing members of families and the community. Experimentation of all sorts is common, including the use of illicit substances, and does not necessarily portend later problems since many adolescents progress through this period and into adulthood without additional significant troubles. Most substances are illegal for youth and use is subject to legal and judicial response. Thus, adolescent risk-taking and experimentation pose serious questions for the juvenile justice system, including how to avoid the widespread criminalization of unacceptable but transitory behavior. One key challenge is to develop interventions that address unacceptable behavior before a youth becomes involved in the juvenile justice system.

For youth that do enter the juvenile justice system, opportunities to provide comprehensive treatment and services for substance abusers and their families should be recognized. There are several points of potential intervention with youth. In a comprehensive system, the first point of intervention is prior to any involvement with the juvenile justice system. This requires the identification of high-risk youth and the provision of services that prevent or minimize involvement with the justice system. Other points of potential intervention are arrest or intake, fact finding hearings, community-based diversion, adjudication, probation, and detention.

Treatment and supervisory responses to youth must be different from those for adults. Youth are much more likely to be substance users and abusers, but not, or not yet, dependent. Thus, a different clinical approach is required. Youth often do not respond well to supervisory techniques that work with adults. The institutional and legal settings for youth and adults are substantially different. And there are youth-specific issues concerning consent, due process, and confidentiality. For youth, the family, community, and schools play a prominent role and must be incorporated into any comprehensive solution. Thus, a collaborative approach, linking youth-related service systems, appears to offer the best opportunity to engage youth and their families in treatment, appropriate supervision, and sustained rehabilitation.

Research on adolescent treatment and supervision is not as extensive as for adults. A major effort will be required to demonstrate interventions that are successful in preventing high-risk youth from becoming involved in the juvenile justice system. Fortunately, there are some promising approaches. One is "strength-based," identifying and building on the positive attributes of youth, their families, and communities, rather than focusing exclusively on what the youth has done wrong. Another approach assesses the youth's behavior in the context of the family system and the community, and fashions interventions that address the family as well as the individual.

Finally, there are compounding factors that cannot be ignored. For one, there is concern that some minority groups are entering the juvenile justice system at a rate disproportionate to their criminal activity. And there are some disturbing statistics that require review. For example, African-American youth, 15 percent of the 10 to 17 year-old population, account for 50 percent of those transferred from juvenile to adult court.<sup>19</sup>

***There is a growing body of science that must be respected.*** There is sufficient hard evidence to support a comprehensive and coherent policy that will be more effective in reducing criminal activity, disease transmission, and long-term expenditures.

## **B. A BRIEF OVERVIEW OF EXISTING KNOWLEDGE**

Our knowledge regarding addiction, treatment, and justice interventions has grown substantially over the past decade. A large and growing body of research is consistently clear on a number of points that are key to public policy. A recent NIDA publication outlines the principles that can be drawn from the research.<sup>20</sup>

**We know that drugs change the brain. Recent research has taught us that, although addiction is a complicated state, it invariably involves changed brain chemistry. The brain chemistry of the addict has become different from that of the person who does not use drugs. Indeed, the addict's brain is different from that of most people who have used drugs, although all users run the risk of altered brain chemistry over time. With heavy, frequent drug use the change can be profound.**

Furthermore, drug seeking and using behavior trains the brain. Addicts are not simply sick people. Rather they are sick people who engage in a web of behaviors that exacts a toll on the health and safety of all society's institutions, starting with the family. Addicts cannot, and some abusers do not want to, control their behavior. Many resist efforts to bring their actions in line with the requirements of society. Some suffer from co-occurring mental disorders that further complicate rehabilitation.

Structured interventions can get chronic abusers of drugs and alcohol into treatment, retain them, provide the supervision and support required to start them on recovery, and enable them to maintain their recovery over the long term. Long-term progress in reducing and managing this population requires a rehabilitation approach that: confronts and exposes thinking errors and the addictive lifestyle, provides for values and character development, engages the chronic user or addict in active participation, matches specific services to specific needs, and continues needed services for an adequate time period.

The results of treatment are well established. Drug and alcohol abusing and dependent people who participate in treatment, when compared to those who do not, decrease their use, decrease their criminal activity, increase their employment, improve their social and interpersonal functioning, and improve their physical health. Drug use and criminal activity decrease for virtually all who enter treatment, with increasingly better results with treatment retention.

Intensive (often-residential) drug treatment or therapy is essential for many abusers and addicts but may be of variable duration. The services that prepare the addict for recovery and support continuing recovery, while less expensive, are invariably of long duration. The provision of vocational skills, social survival skills, relapse prevention skills, social supervision and support, and medication will all be necessary to some extent, to allow the continuation of the process that begins with intensive treatment. During this transitional,

or "aftercare," period self-help groups, social model programs, faith-based programs, culture-based programs, and other community groups can offer the structure, sanctions, and support that are so critically needed. Such programs are distinct from formal treatment and might better be called "recovery" programs.

Thorough and continuous assessment, treatment planning, case management, supervision, and accountability must be integral parts of treatment. Residential treatment programs with carefully planned and executed transitional services, supervision and support have significantly better outcomes than programs without such services. Considerable staff training will be required to incorporate these critical elements.

Treatment for the drug and alcohol abusing and dependent offenders can be enhanced when there is direct criminal justice involvement. The threat of criminal justice sanction motivates offenders to enter treatment and, perhaps more important, motivates them to stay in treatment for a period of time sufficient for behavior change. However, external threats alone do not appear sufficient for the maintenance of stable recovery, which requires internal motivation. The personalized supervision and positive reinforcement of a community-based team, which includes the judge, can provide encouragement and incentive for offenders. Furthermore, motivational interviewing and other clinical steps to foster treatment engagement are showing promise. In correctional institution settings, effective programs are often provided in a segregated treatment unit to foster engagement.

Drug and alcohol abusing and dependent criminal offenders present problems of both substance abuse and criminal behavior. Offenders' drug dependence can not explain away criminal acts for which they are, and must be held, accountable. This applies equally to recidivism, which is not simply an indication of program failure. For some offenders, drug and alcohol abuse is just one of a number of aberrant behaviors. For others, drug craving, seeking, and using behaviors have virtually taken over their lives. For still others, mental illness is also present. And for almost all, criminal thinking patterns must be confronted as well as drug dependence and mental illness. All contribute to criminality and hinder change.

## **C. GUIDING PRINCIPLES FOR POLICY**

### ***1. Confronting the Myths***

Certain myths maintain a strong hold on many policy makers, and hinder the provision of effective treatment. Among them are the following.

*"Treatment is soft on criminals." Providing offenders with substance abuse treatment services amounts to leniency in punishment. Offering the offender treatment services undercuts the punishment goals of a sentence.*

*Furthermore, "Offenders do not deserve treatment." Treatment is a privilege that offenders do not warrant because of their involvement in crime.*

*Finally, "Treatment can not be offered in prison, jail, or community probation settings." Because substance abuse treatment is a specialized service that addresses underlying behaviors, it can not be offered effectively in punishment environments. At a minimum, services offered in these environments will be compromised*

None of these myths holds up under scrutiny. Treatment is hard. The physiological and psychological consequences of substance abuse make it so. Dropout rates are extremely high for those who seek treatment on their own, when they confront what is required of them. Many offenders, given the option, choose to do time rather than work at the personal change that treatment demands. It is also important to note that treatment is not solely, or even primarily, a service for the benefit of substance disordered offenders. Although offenders clearly benefit with the acceptance of personal accountability; public safety, public health, and the public purse are the primary beneficiaries of treatment for this population. All suffer when treatment is unavailable, withheld, or poorly delivered.

The real question is not whether offenders deserve treatment but whether it is sound practice to release untreated, addicted offenders back into their communities. Personal accountability is essential to long-term recovery and must be practiced in real life settings.

Since the vast majority of incarcerated offenders will eventually return to their communities, public safety demands that society: identify those who can be managed in community justice programs without need for incarceration; identify those incarcerated offenders who need treatment; and provide post-incarceration supervision and support.

Regarding the apparent antipathy of the objectives of the treatment and justice systems, actual experience indicates that they can be mutually re-enforcing. Indeed, the research suggests that, among justice interventions, only treatment reduces recidivism. RAND Corporation researcher, Joan Petersilia has reviewed 15 years of experimenting with intermediate sanctions and found that treatment services are the only component that is effective in reducing recidivism. Earlier studies of boot camps and intensive supervision probation, by the National Institute of Justice, had similar findings. Prison treatment studies, especially for programs with appropriate follow up, yield the same results. Control efforts, including incarceration, monitoring, and drug testing have limited impact by themselves; however, in concert with treatment they can change the behavior of offenders. Without treatment to provide new skills and approaches, long term change in the values, attitudes, and subsequent behaviors of offenders is unlikely to occur.

## ***2. Applying What Science and Experience Have Taught***

Given the chronic relapsing nature of addiction, the consequences of addictive behavior for the individual, the family, and society, and the condition of existing service systems, our efforts to prevent and treat addictive disorders should be governed by the following:

- Interventions should increase long-term community safety, reduce long-term threats to public health, and reduce long-term direct and indirect costs to society.
- Interventions should increase order and safety in correctional facilities.
- Interventions should increase personal accountability and responsibility on the part of substance disordered offenders.
- Interventions should reduce community factors ("risk" factors) that contribute to substance abuse, and strengthen factors ("protective" factors) that minimize the risk of substance abuse.
- Community and family support systems should be encouraged and assisted;
- Any significant opportunity to get those who abuse alcohol and drugs into a formal treatment and rehabilitation program should be seized. The justice system offers an

immediate opportunity to engage significant numbers in treatment and long term recovery.

- Existing justice system interventions -- treatment and rehabilitation, intermediate sanctions, TASC programs, justice treatment networks, drug courts, assessment centers, halfway houses -- should be expanded; and the expansion of capacity must be accompanied by training, technical assistance, and formal means (e.g., certification) to assess and ensure competence on the part of treatment providers.
- Newly established treatment programs should develop a comprehensive implementation plan that includes measures to ensure and maintain staff competency.
- All treatment programs should employ a comprehensive assessment instrument at the point of intake, and update that assessment periodically during the course of treatment and patient recovery. Furthermore, programs should incorporate performance measures to assess offender progress toward clearly defined goals and objectives and respond to progress or the lack thereof, with appropriate rewards and sanctions.
- All treatment programs should assess and address life skills deficits and mental and primary health problems, involving the offender's family to the extent possible and appropriate.
- All treatment programs should develop a formal, long-term treatment plan, in accordance with the results of the assessment; and review and revise it with periodic assessments.
- All treatment programs should recognize and respond to differences in gender, age, and ethnicity or culture.
- Programs should consider cognitive behavioral and social learning models that have been demonstrated to be effective in changing the behavior of offenders. Social learning models that confront criminal thinking patterns and teach offenders problem solving skills, socialization, pro-social values, and the restructuring of thoughts and actions are effective in reducing recidivism.
- All formal treatment interventions should include orientation, compliance motivation training, and relapse prevention training in a phased course of treatment and recovery support.
- Sanctions for non-compliance and rewards for compliance should be established clearly, 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. Potential indicators include retention, substance use, dealing, relapse, and criminal recidivism.**
- **A formal supervision and support function should be designated for each person who completes the initial stage of treatment, to provide management and supervision and ensure continuing compliance with the treatment plan during the period of transition and reentry into the community.**

## **D. RESEARCH AND TECHNICAL ASSISTANCE PRIORITIES**

Community actions to establish and implement sound policy require the support of continuing research, technical assistance, and training. The following outline addresses topics of priority importance identified by government and non-government agencies.

### ***1. Research***

- **Initiate improvements in the dissemination of best practices, including the provision of step-by-step implementation manuals.**
- **Conduct process research and evaluations and publish guidance on ways to increase retention in treatment; ways to reduce relapse; ways to conduct treatment that foster progress from external coercion to internal motivation.**
- **Conduct process and outcome research and evaluations, and publish guidance on the provision of substance abuse treatment to juvenile justice populations.**
- **Conduct research and demonstrations on the development and application of pharmacotherapies and behavioral therapies for the treatment of dependence on/abuse of cocaine/crack, opiates, marijuana, and stimulants including methamphetamine.**
- **Conduct evaluations and disseminate guidance regarding low-cost treatment and self-help transitional and follow up support (e.g., social model programs, safe and sober houses).**
- **Conduct long-term longitudinal studies of treatment at all stages of the criminal and juvenile justice systems.**
- **Evaluate the effectiveness of treatment and supervision programs for adults and juveniles designed to be culturally, gender and developmentally appropriate.**
- **Evaluate integrated mental health and substance abuse approaches for juveniles and adults with co-occurring disorders.**
- **Evaluate the impact of family involvement, and the family as the unit of treatment.**
- **Evaluate rehabilitation programs that include comprehensive skills building, job training directly linked to employment, and viable education programs.**
- **Evaluate cognitive behavioral approaches for juveniles.**

## ***2. Technical Assistance***

Provide a range of technical and program development assistance services to facilitate the acceptance and implementation of best practices, and professional staff development, for treatment and supervision.

- Mentor sites
- Intergovernmental and interagency websites
- Best practices manuals (ongoing interagency series)
- National and regional conferences and workshops (ongoing series)
- Training institutes
- On- and off-site technical assistance

## **E. PERFORMANCE MEASURES OF EFFECTIVENESS**

The *National Drug Control Strategy's* purpose is to reduce drug use and availability by 50 percent by 2007. It seeks to reduce drug-related crime and violence by 15 percent before the year 2002 and 30 percent by the year 2007. Reducing drug consumption by chronic users is one of the most promising ways to decrease this crime. ONDCP has developed, in coordination with all federal drug control program agencies, ninety-four measurable targets to gauge progress towards these five- and ten-year objectives. The measures that are directly related to this initiative include:

**Drug-related violent crime.** By 2002, achieve a 20 percent reduction in the rate of homicides, robberies, rapes, assaults, and crimes against property associated with illegal drugs as compared to the 1996 base year. By 2007, achieve at least a 40-percent reduction

**Drugs and recidivism.** By 2002, reduce by 10 percent the proportion of identified drug-using offenders who are rearrested for new felonies or serious misdemeanors within a 1-year period following their release from supervision using 1998 as the base year. By 2007, reduce this proportion by at least 25 percent.

**Inmate access to illegal drugs.** By 2002, reduce by 25 percent the proportion of inmates who test positive for illegal drugs during their incarceration in Federal, State, county, or local detention facilities as compared to the positive test rate in the 1997 base year. By 2007, reduce positive tests by 50 percent.

**Drug testing policies.** By 1999, in concert with the States, adopt drug testing policies within the criminal justice system which: clearly articulate the purposes and goals of drug testing; and prescribe responses; target appropriate populations based in an assessment of need for each type of drug; specify testing types and frequency; specify how offenders will be targeted for testing; and detail staff training requirements.

**Positive drug test responses.** By 1999, in concert with State correctional agencies and local correction offices, adopt processes to ensure that there is a response to every positive test or assessment of need; including event documentation, enhanced case management, increased judicial supervision, or imposition of other graduated sanction and treatment interventions.

**Treatment availability.** By 2002, increase by 10 percent the proportion of identified drug-using offenders who are provided substance abuse treatment interventions as compared to the 1997 base year. By 2007, increase this proportion by at least 25 percent.

**Breaking-the-Cycle ("BTC") demonstration projects.** By 2000, increase the number of juvenile and adult sites demonstrating the principles embodied in the "BTC" research demonstration project. By 2001, refine the BTC research demonstration project and develop revised models for State and local governments.

**Drug-crime focused court reform.** By 2002, 60 percent of the States and metropolitan areas (as defined by the U.S. Census Bureau) will implement drug-crime based judicial reform or specialization of the courts system to elicit a decrease in drug-crime recidivism. By 2007, 80 percent of States and metropolitan areas will show a decrease in the recidivism rate compared to the base year.

**Effectiveness study.** By 2002, research the relative success of law enforcement and disseminate this information to at least 80 percent of law enforcement or drug prevention and treatment agencies. By 2007, ensure all related agencies have received the research findings and 90 percent have implemented selected initiatives.

## **F. ACKNOWLEDGEMENTS, BIBLIOGRAPHY, AND ENDNOTES**

### ***1. Summit Participants***

On June 25, 1999, leaders from 40 stakeholder organizations met in Washington to advise DOJ, HHS, and ONDCP on the essential content of national policy addressing substance abuse treatment and the justice systems. A spirited discussion was held with ONDCP Director McCaffrey, Assistant Attorney General Laurie Robinson, SAMHSA Deputy Administrator Joseph Autry, and NJ Director Jeremy Travis. These organizations provided a number of helpful suggestions in both oral and written form and special thanks is owed to all the people listed below.

Stephen Amos, Office of Justice Programs,  
Ron Angelone, Association of State Correctional Administrators,  
Allen Ault, National Institute of Corrections,  
Deb Beck, National Alliance for Model State Drug Laws,  
George Camp, Association of State Correctional Administrators,  
Mike Dalich, Office of Justice Programs,  
Gloria Danziger, American Bar Association,  
Pete Delaney, National Institute on Drug Abuse,  
Ron Dyson, Administrative Office of the U.S. Courts,  
Bennett Fletcher, National Institute on Drug Abuse,  
Bruce Fry, Center for Substance Abuse Treatment, SAMHSA  
Irene Gainer, National TASC Association,  
Ron Garvin, American Judges Association,  
Betty Gondles, American Correctional Association,  
Jack Gustafson, National Association for State Alcohol and Drug Abuse Directors,  
Tom Henderson, National Center for State Courts,  
Wes Huddleston, National Drug Court Institute,  
Linda Wolf Jones, Therapeutic Communities of America,  
George Kanuck, Center for Substance Abuse Treatment,  
Ken Kerle, American Jail Association,  
Judy Kimsey, Washington Baltimore HIDTA,  
Michael Link, National TASC Association,  
Larry Meachum, Office of Justice Programs,  
Don Murray, National Association of Counties,  
Juan Otero, National League of Cities (written comments only)  
Liz Pearson, National Criminal Justice Association,  
Renee Robinson, Washington Baltimore HIDTA,  
Paul Samuels, Legal Action Center,  
Kathy Schwartz, State Justice Institute,  
Jill Shibles, National American Indian Court Judges Association,

Mary Shilton, International Community Corrections Association,  
Patrick Tarr, Department of Justice,  
Jeff Tauber, National Association of Drug Court Professionals,  
Gary Tennis, National Alliance for Model State Drug Laws, and  
National District Attorneys Association,  
Scott Wallace, National Legal Aid and Defenders Association,  
Beth Weinman, Federal Bureau of Prisons.  
Steve Wing, Substance Abuse and Mental Health Services Administration,  
Carl Wicklund, American Probation and Parole Association, and  
Lauren Ziegler, Office of Juvenile Justice and Delinquency Prevention.

## ***2. Interagency Working Group***

Individuals who worked with ONDCP crafting language, suggesting edits, and providing continuing counsel warrant special recognition. These include:

Stephen Amos, Office of Justice Programs,  
Christine Cichetti, Department of Health and Human Services,  
Pete Delaney, National Institute on Drug Abuse,  
Nick Demos, Center for Substance Abuse Treatment,  
Bruce Fry, Center for Substance Abuse Treatment,  
Patricia Malak, Office of Justice Programs,  
Patrick Tarr, Department of Justice,  
Faye Taxman, University of Maryland,  
Beth Weinman, Federal Bureau of Prisons,  
Steve Wing, Substance Abuse and Mental Health Services Administration, and  
Lauren Ziegler, Office of Juvenile Justice and Delinquency Prevention.

## ***3. Bibliography***

David M. Altschuler, Troy L. Armstrong, and Doris Layton MacKenzie. *Reintegration, Supervised Release, and Intensive Aftercare*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. *Juvenile Justice Bulletin*. NCJ-175715. July 1999.

Alan J. Beck and Christopher J. Mumola. *Prisoners in 1998*. U.S. Department of Justice, Office of Justice Programs. *Bureau of Justice Statistics Bulletin*. NCJ-175687. August 1999.

Thomas P. Bonczar. *Characteristics of Adults on Probation, 1995*. U.S. Department of Justice, Office of Justice Programs. *Bureau of Justice Statistics Special Report*. NCJ-164267. December 1997.

Thomas P. Bonczar and Lauren E. Glaze. *Probation and Parole in the United States, 1998*. U.S. Department of Justice, Office of Justice Programs. Office of Justice Statistics Bulletin. NCJ-178234. August 1999.

Camille Graham Camp and George M. Camp. *Probation and Parole*. The Corrections Yearbook 1998. South Salem, NY: Criminal Justice Institute, Inc.

John J. DiIulio, Jr. *Drug Sentencing Run Amok*. The National Review. May 17, 1999.

Paula M. Ditton. *Mental Health and Treatment of Inmates and Probationers*. U.S. Department of Justice, Office of Justice Programs. Office of Justice Statistics Special Report. NCJ-174463. July 1999.

Tina L. Dorsey and Marianne W. Zawitz. *Drug and Crime Facts*. U.S. Department of Justice, Office of Justice Programs, Office of Justice Statistics. NCJ-165148 October 1999.

Paul Gendreau and Claire Goggin. *Correctional Treatment: Accomplishments and Realities*. In: *Correctional Counseling*. 3<sup>rd</sup> Edition. Cincinnati, OH: Anderson Press. 1996.

Darrell K. Gilliard. *Prison and Jail Inmates at Midyear 1998*. U.S. Department of Justice, Office of Justice Programs, Office of Justice Programs. NCJ-173414. March 1999.

Institute of Behavioral Research at Texas Christian University. *DATAR 2: A Review of Findings and Treatment Tools*. Research Roundup, Vol. 9, No. 2. Summer 1999.

Kevin Knight. *Corrections-Based Drug Treatment: An Overview of Research Findings*. Presented at Measuring Treatment Process sponsored by U.S. Department of Justice, Bureau of Prisons. August 5, 1999.

Leena Kurki. *Incorporating Restorative and Community Justice Into American Sentencing and Corrections*. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. Sentencing & Corrections, Issues for the 21<sup>st</sup> Century – Papers from the Executive Session on Sentencing and Corrections, No. 3. September 1999.

Barrie Maguire and Tom Teepen. *U.S. Spans World in Juvenile Punishment*. The Baltimore Sun. November 16, 1999.

Kathleen Maguire and Ann L. Pastore eds. *Bureau of Justice Statistics Sourcebook of Criminal Justice Statistics – 1998*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. NCJ-176356. 1999.

The National Center on Addiction and Substance Abuse at Columbia University. *Behind Bars: Substance Abuse and America's Prison Population*. January 1998.



National GAINS Center. *The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System*. Just the Facts. Spring 1997.

National Institute on Drug Abuse, National Institutes of Health. *Preventing Drug Use Among Children and Adolescents, A Research-Based Guide*. NIH Publication No. 97-4212. March 1997.

National Institute on Drug Abuse, National Institutes of Health. *Principles of Drug Treatment, A Research-Based Guide*. NIH Publication No. 99-4180. October 1999.

National Institute on Drug Abuse, National Institutes of Health. *Untitled Document, overview of NIDA-funded research programs: drug treatment initiatives for criminal justice offenders*. In Press.

The Office of National Drug Control Policy. *Conference Proceedings: Consensus Meeting on Drug Treatment in the Criminal-Justice System, Breaking the Cycle with Science-Based Policy*. March 1998.

The Office of National Drug Control Policy. *Summit Proceedings: Substance Abuse and the Criminal Justice System, Summit of Stakeholders*. June 1999.

Anne Morrison Piehl, Bert Useem, and John J. Dilulio, Jr. *Right-Sizing Justice: A Cost-Benefit Analysis of Imprisonment in Three States*. Center for Civic Innovation at the Manhattan Institute. No. 8. September 1999.

Peter Reuter and Susan Everingham. *Comparing the Cost-Effectiveness of Federal Minimum Sentences and Other Federal Enforcement Programs*. Testimony presented to the Subcommittee on Crime of the House Committee on the Judiciary, July 29, 1999. RAND Drug Policy Research Center.

William J. Sabol and John McGready. *Time Served in Prison by Federal Offenders, 1986-97*. U.S. Department of Justice, Office of Justice Programs. Office of Justice Statistics Special Report. NCJ-171682. June 1999.

The Sentencing Project. *Drug Policy and the Criminal Justice System*. Briefing/Fact Sheet. October 1999.

James J. Stephan. *State Prison Expenditures, 1996*. U.S. Department of Justice, Office of Justice Programs, Office of Justice Statistics. NCJ-172211. August 1999.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Center for Substance Abuse Treatment. *Addressing the Needs of Homeless Persons with Co-Occurring Mental Illnesses and Substance Use Disorders, A Technical Assistance Package*. May 1997.

Faye S. Taxman. *Reducing Recidivism Through a Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community*. Prepared for the Office of National Drug Control Policy Treatment and Criminal Justice System Conference. February 20, 1998.

U.S. Department of Justice, Office of Justice Programs. *Reentry Courts: Managing the Transition from Prison to Community, A Call for Concept Papers*. September 1999.

U.S. Department of Justice. *Report to Congress: Substance Abuse Treatment Programs in the Federal Bureau of Prisons*. January 1999.

Harry K. Wexler and Kevin Knight. *TC Outcome Research: An Overview*. National Development and Research Institutes, Inc. and Institute of Behavioral Research, Texas Christian University. 1999.

#### **4. Endnotes**

---

<sup>1</sup> Alan J. Beck and Christopher J. Mumola. *Prisoners in 1998*. U.S. Department of Justice, Office of Justice Programs. Bureau of Justice Statistics Bulletin. NCJ-175687. August 1999.

<sup>2</sup> William J. Sabol and John McGready. *Time Served in Prison by Federal Offenders, 1986-97*. U.S. Department of Justice, Office of Justice Programs. Office of Justice Statistics Special Report. NCJ-171682. June 1999.

<sup>3</sup> U.S. Department of Justice, Office of Justice Programs. *Reentry Courts: Managing the Transition from Prison to Community, A Call for Concept Papers*. September 1999.

<sup>4</sup> Alan J. Beck and Christopher J. Mumola. *Prisoners in 1998*. U.S. Department of Justice, Office of Justice Programs. Bureau of Justice Statistics Bulletin. NCJ-175687. August 1999.

<sup>5</sup> William J. Sabol and John McGready. *Time Served in Prison by Federal Offenders, 1986-97*. U.S. Department of Justice, Office of Justice Programs. Office of Justice Statistics Special Report. NCJ-171682. June 1999.

<sup>6</sup> James J. Stephan. *State Prison Expenditures, 1996*. U.S. Department of Justice, Office of Justice Programs, Office of Justice Statistics. NCJ-172211. August 1999.

<sup>7</sup> Camille Graham Camp and George M. Camp. *Probation and Parole*. The Corrections Yearbook 1998. South Salem, NY: Criminal Justice Institute, Inc.

<sup>8</sup> The Congressionally-mandated 1997 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.

---

<sup>9</sup> U.S. Department of Justice, Office of Justice Programs. *Reentry Courts: Managing the Transition from Prison to Community, A Call for Concept Papers*. September 1999.

<sup>10</sup> Anne Morrison Piehl, Bert Useem, and John J. DiIulio, Jr. *Right-Sizing Justice: A Cost-Benefit Analysis of Imprisonment in Three States*. Center for Civic Innovation at the Manhattan Institute. No. 8. September 1999.

<sup>11</sup> A 1997 CASA report estimated that 70 to 80 percent of prisoners are in need of substance abuse treatment, with less than 20 percent receiving it. More formal estimates of treatment need based on established criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders [DSM]) yield lower but significant numbers. The Federal Bureau of Prisons (BOP) estimates about 30.5 percent to be in need of treatment. A 1997 study of adult arrestees in Baltimore, by the University of Maryland's Center for Substance Abuse Research (CESAR), estimates 46 percent to be in need of treatment. Less formal estimates by state corrections directors approach the CASA numbers. In a survey conducted by the Association of State Correctional Administrators (ASCA) 31 states indicated, on average, 70.3 percent in need of treatment (range 11.3 to 85 percent), 12.7 percent receiving some form of treatment (range 2.1 to 45.3 percent), and 14.2 percent completing treatment before release from prison. A conservative 50 percent estimate yields about 2.5 million people in need of treatment. The most generous estimate of the percent of probationers receiving any treatment, by BJS for 1995, found 38 percent (most for alcohol). The BJS estimate for prisons in 1997 was 20 percent. Without any consideration of the quality of the programs being offered, a very conservative estimate would be that over a million offenders under criminal justice supervision need, and are not getting, drug treatment (500,000 probationers, 350,000 prisoners, and 160,000 jail inmates).

<sup>12</sup> Data provided by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the Center for Substance Abuse Treatment (CSAT).

<sup>13</sup> The 1997 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.

<sup>14</sup> National GAINS Center. *The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System*. Just the Facts. Spring 1997.

<sup>15</sup> John J. DiIulio, Jr. *Drug Sentencing Run Amok*. The National Review. May 17, 1999.

<sup>16</sup> Camille Graham Camp and George M. Camp. *Probation and Parole*. The Corrections Yearbook 1998. South Salem, NY: Criminal Justice Institute, Inc.

---

<sup>17</sup> National GAINS Center. *The Prevalence of Co-Occurring Mental and Substance Abuse Disorders in the Criminal Justice System*. Just the Facts. Spring 1997.

<sup>18</sup> Barrie Maguire and Tom Teepen. *U.S. Spanks World in Juvenile Punishment*. The Baltimore Sun. November 16, 1999.

<sup>19</sup> Barrie Maguire and Tom Teepen. *U.S. Spanks World in Juvenile Punishment*. The Baltimore Sun. November 16, 1999.

<sup>20</sup> National Institute on Drug Abuse, National Institutes of Health. *Principles of Drug Treatment, A Research-Based Guide*. NIH Publication No. 99-4180. October 1999.

PROPERTY OF  
National Criminal Justice Reference Service (NCJRS)  
Box 6000  
Rockville, MD 20849-6000