PUBLICLY FUNDED SUBSTANCE ABUSE PROGRAMS FOR ADULT OFFENDERS IN WASHINGTON STATE

MAY 1992

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OVERVIEW

On July 1, 1991, more than 90,000 offenders were under some form of supervision in Washington's criminal justice system. A significant number of these offenders have been recommended for substance abuse treatment by criminal justice professionals. An even larger proportion are in need of treatment. Criminal justice professionals generally concur that many more offenders require substance abuse treatment than the treatment system can presently handle. Because of this, and because of significant interest in some quarters to use substance abuse treatment as a substitute for or supplement to the normal complement of criminal sanctions for some offenders, the Advisory Committee to the 1991 Capacity Study: Offender Placements in Washington State successfully argued for an assessment of the substance abuse treatment system. This report presents the findings of that assessment. Funding for this study was provided by the Washington State Department of Corrections Partnership Program.

PUBLICLY FUNDED TREATMENT IN WASHINGTON STATE

- Public funds for substance abuse treatment in the community come directly or indirectly from the Division of Alcohol and Substance Abuse of the Department of Social and Health Services (DASA).

- Community-based treatment includes several types of residential treatment, lasting from 30 to 180 days, and outpatient treatment, lasting 90 days. Alcoholism and Drug Abuse Treatment and Support Act (ADATSA) -funded treatment cannot exceed 180 days in any two-year period.

- Prison treatment is a 91-hour intensive outpatient program. Treatment in state partial confinement is somewhat less intensive. Prison and state partial confinement treatment programs are funded by the Department of Corrections.

- There is no comparable treatment for local jails. Some jails permit self-help groups. King County has a treatment program for lesser offenders.

TREATMENT EFFECTIVENESS

- There is considerable evidence that drug treatments, particularly methadone maintenance and therapeutic communities, are effective. Other forms of drug treatment appear to have positive effects, but that impact is less supported by current studies.

- The work on effectiveness of alcohol treatment is less definitive. There have been fewer studies for each specific modality. What has been done suggests that some, but not all, forms of treatment are effective.

- Treatment of offenders while in prison has been shown to work if treatment follows the therapeutic community approach.

- An assessment of prison treatment in Washington showed high completion rates and positive impact on subsequent behavior.

- Assessments of completion rates for both ADATSA and all publicly funded clients show varying rates of completion depending upon the modality. Clients are more likely to finish an inpatient treatment than an outpatient treatment.

CRIMINAL JUSTICE DEMAND FOR TREATMENT

- An estimated 465,062 Washington residents are potential clients of substance abuse treatment agencies. They are dependent on and/or abuse alcohol or illicit drugs, or both. This number includes both offenders and all others in need of treatment.

- Two methods were used to estimate criminal justice demand for substance abuse treatment.

    1. Using an approximation of the number of treatment orders to estimate substance abuse treatment needs resulted in an estimate of approximately 50,000 offenders needing treatment each year.

    2. Using prevalence rates for substance abuse in the confined population compared to the general population resulted in an estimate of approximately 25,000 offenders as potential clients of substance abuse treatment agencies.

- About half of all people assessed as needing treatment actually enter treatment. Consequently, the demand for treatment services attributable to offenders is likely to be somewhere between 12,500 and 25,000 clients per year.

CURRENT CAPACITY OF PUBLICLY FUNDED TREATMENT

- The publicly funded substance abuse treatment system includes 781 beds for residential treatment, 2,366 slots for outpatient treatment, and prison-based chemical dependency treatment with a capacity for 1,593 inmates per year. The residential and outpatient treatment is distributed across the state.

- These programs serve at minimum 16,648 clients per year. Since some clients are served by more than one program, this is not an unduplicated count. Outpatient services especially serve many clients whose treatment is partially provided by public funds, so the total number served is probably considerably larger.

- DASA data indicate 31,069 clients were served in both types of programs.

BARRIERS TO SUFFICIENT TREATMENT

- The most significant barriers to treatment are too few resources and thus too few treatment slots.

- Additional important barriers are: doubts about treatment viability; difficulties in designing and running programs for offenders; and the lack of linkages between the treatment and criminal justice systems and between the inpatient and the outpatient portions of the two systems.

- Both treatment professionals and criminal justice professionals have reservations about substance abuse treatment for offenders. These reservations are important barriers to effective treatment for offenders.

- Delays for individuals in being assessed for treatment or entering treatment may negatively affect program participation. As many as half of the Alcoholism and Drug Abuse Treatment and Support Act (ADATSA) funded clients in Washington drop out before entering treatment.

- Offenders face perhaps the most difficult barriers. Often an offender who has a court order for treatment finds s/he cannot pay for that treatment, or is not eligible for public funding, or cannot find an appropriate treatment to enter. Such an offender will often find him- or herself serving a sentence in confinement even if s/he wanted to get into treatment.

COST OF PROVIDING TREATMENT SERVICES

- Given the current mix of offender clients in community treatment modalities, not counting methadone maintenance, the publicly funded treatment cost averaged $25 a day. With an average stay in all treatments of 145 days, the average cost for a full course of was $3,625.

- The average cost for each offender entering treatment in prison or state partial confinement in FY 1991 was $660.

- The average reimbursement rate is $52.94 a day for intensive inpatient treatment.
- The average reimbursement rate for recovery house beds is $30.25 a day.
- Reimbursement rates for extended care recovery house beds average $24.97 per day.
- Long term residential treatment beds are available for drug addicts and for mentally ill chemical abuser (MICA). The average daily reimbursement rate is $42.96 for drug treatment $75.07 for MICA treatment.
- Intensive outpatient treatment reimbursements average $426 a month.
- Adult and ADATSA outpatient treatment slots are estimated to have an average reimbursement rate of $250 a month.

IMPLICATIONS FOR THE FUTURE

- If the present level of treatment services is provided to the projected increase in the number of offenders in Washington state, in 1996 it will cost about $20 million per year more than is currently being spent.
- Using the current mix of treatment modalities plus increased community supervision as a substitute for confinement in jail or prison would cost nearly the same as confinement alone during the six months of treatment and would cost less than incarceration shortly thereafter. Thus, if treatment plus supervision is substituted for confinement terms longer than six months, savings would accumulate rapidly.
- Treatment failure rates have little impact on the cost effectiveness of treatment versus confinement.
- If greater reliance is placed on residential programs for offenders, the savings from diversion from jail to high or moderate cost non-incarcerative control plus treatment is not as great as the cost of treatment. Diversion from state work release or minimum security prison is financially attractive if confinement time is reduced by seven to eight months or more.
- There are also non-quantifiable cost benefits to providing treatment services to offenders. Long term savings can result from the reduction in repeat offense due to successful treatment. Because of the high cost of incarceration, even a small amount of success in treatment can result in significant savings from avoided future incarcerations.

EXECUTIVE SUMMARY

Criminal justice professionals, particularly those involved in sentence recommendations and decisions, have long said that many more offenders require substance abuse treatment than the treatment system can handle. Because of this, and because there is ongoing interest in some quarters to expand the use of substance abuse treatment for some offenders as an alternate or supplement to criminal sanctions, members of the Advisory Committee for the 1991 Capacity Study: Offender Placements in Washington State successfully argued for an assessment of substance abuse treatment capacity and demand in Washington State. This report presents the findings of that assessment. Funding for this study was provided by the Washington State Department of Corrections Partnership Program.

PUBLICLY FUNDED TREATMENT IN WASHINGTON STATE

Public funds, of any kind, pay for slightly less than half the treatment services available in Washington.

The services outlined from the Washington Administrative Code cover the range of treatment services available through public funds in Washington. These include assessment (DWI and alcohol/drug), alcohol/drug information school, outpatient (intensive, regular and ADATSA), methadone treatment, intensive inpatient, recovery house, extended care recovery house, and long term treatment services.

After clients are screened, they may be evaluated through one of two assessments: DWI assessment or alcohol/drug assessment. Other publicly funded clients may be screened and assessed by the agency that will provide outpatient or inpatient services.

Following assessment, a qualified counselor will recommend one or a combination of the following treatment paths for the client.

1. Alcohol/drug school for 8 to 15 hours of instruction.
2. Regular outpatient service for 90 days.
3. Intensive outpatient services for 90 days.
4. Intensive inpatient service for 30 days.
5. Intensive inpatient service for 30 days, then outpatient service for 90 days.
6. Intensive inpatient service, then recovery house for 60 days, then outpatient service for 90 days.
7. Extended care residential services for 90 days, then outpatient service for 90 days.
8. Drug residential service for 180 days.

9. Mentally Ill Chemical Abusers (MICA) residential treatment for 30 days, then dual diagnosis residential treatment for 90 days.

Publicly funded treatment is limited to 180 days within a 24 month period. A client may move in and out of various treatment modalities, but can receive treatment for only a six month period. Because most programs are part time, except for 180-day inpatient programs, the maximum amount of treatment received is substantially less than six months.

The Department of Corrections contracts for substance abuse treatment services in 15 of its institutions and four work release centers. They give priority to inmates with court orders for treatment.

TREATMENT EFFECTIVENESS

There is considerable evidence that drug treatments, particularly methadone maintenance and therapeutic communities, are effective. Other forms of drug treatment appear to have positive effects but that impact is less supported by current studies. The work on effectiveness of alcohol treatment is less definitive. There have been fewer studies for each specific modality. What has been done suggests that some, but not all, forms of treatment are effective. Treatment of offenders while in prison has been shown to work if treatment follows the therapeutic community approach.

An assessment of prison treatment in Washington showed high completion rates and positive impact on subsequent behavior. Assessments of completion rates for both ADATSA and all publicly funded clients show varying rates of completion depending upon the modality. Clients are more likely to finish an inpatient treatment than an outpatient treatment.

Alcohol treatment outcomes are less definitive than those for drug treatment. Many treatment variations have developed, complicating the assessment of their effects, and controlled studies have produced mixed results. For example, some national studies show that 40 to 50 percent of persons dependent on alcohol will alter their drinking behavior with little or no treatment. On the other hand, there is some evidence to suggest that there may be a relationship between type of alcoholic and successful intervention by a specific type of treatment. Perhaps the primary conclusion of studies concerning alcohol treatment is that matching clients with treatment shows promise of improving outcomes.

For any treatment program to be minimally effective it must be of sufficient duration. Some say that for any drug treatment program to have a positive impact it must last longer than 90 days.

CRIMINAL JUSTICE DEMAND FOR TREATMENT SERVICES

Whatever the actual demand for treatment services may be, it is very large. First of all, the number of offenders under some form of criminal justice control in Washington is substantial. A recent survey of offender placements concluded that more than 90,000 offenders were under some form of state or local control on July 1, 1991.

An estimate of treatment demand attributable to offenders has never been attempted in Washington State. In this report two methods are used to develop an approximation that can be used as a starting point for further analysis and policy development.

Statutorily Generated Demand

In Washington, an offender may be required to have treatment as a condition of a misdemeanor or felony sentence or as a condition of deferred prosecution of a criminal charge.

Under the statutory provisions for misdemeanor sentencing there are two routes into treatment: either through a deferral of prosecution on the condition that the offender participate in a treatment program; or a deferred or suspended jail sentence (probation) which includes an order that the offender take part in a treatment program.

For felons, imposition of conditions is more restricted. The Sentencing Reform Act (SRA) limits the use of treatment orders. Only the First-Time Non-Violent Offender Waiver or the Special Sex Offender Sentencing Alternative (SSOSA) permit treatment conditions. Under the First-Time Offender Waiver, the court can require up to two years of community supervision which may include "outpatient treatment for up to two years or inpatient treatment not to exceed the standard range of confinement for that offense." Special Sex Offender Sentencing Alternative conditions are directed toward sex offender treatment.

Sentences to total confinement may be served in a "facility or institution operated or utilized under contract by the state or any other unit of government for twenty-four hours a day..." This provision permits inpatient treatment under the proper conditions.

Finally, certain felons released from prison to community placement may have treatment requirements while on community supervision.

Computing Demand by Use of Estimated Treatment Orders

Many offenders have substance abuse treatment needs. The Department of Corrections estimates that 82 percent of imprisoned felons have been or are chemically dependent. Data from the 1991 Capacity Study survey indicate that 10 percent of the misdemeanor deferred prosecution cases, 85 percent of the misdemeanor probation cases and 17 percent of the felons on community supervision have been ordered to

treatment by the court of jurisdiction. A significant portion of these orders are for substance abuse treatment.

Based upon these rates, as many as 50,000 offenders may need substance abuse treatment. This includes about 38,800 offenders under local criminal justice control and about 11,700 under state control.

Computing Demand by Use of Prevalence Rates

A major National Institute of Mental Health study of prevalence of mental disorders reported lifetime prevalence rates for substance, alcohol and drug abuse disorders in the community and for the detained offender population. This study suggests that the substance abuse rates for offenders can be derived if we know something about those rates for the general population.

Substance abuse rates for offenders are much higher than for the general population. According to the NIMH study, the lifetime rates are nine times higher for offender drug disorders and four times higher for alcohol disorders than for the general population. The combined rates for offender substance abuse are 4.3 times that of the general population.

The Department of Social and Health Services Division of Alcohol and Drug Abuse (DASA) Needs Assessment Report for 1990 determined that there were 465,062 possible adult clients in Washington. This is equivalent to an overall substance abuse prevalence rate in Washington State of 9.6 percent.

Using the Washington prevalence rate for the total population and multiplying by 4.3 to adjust for the higher prevalence of institutionalized populations, the rate for confined offenders should be about 41 percent. In larger prevalence studies, persons under community supervision have been treated as though they were just like any other community resident. In Washington that would mean a prevalence rate of 9.6 percent for offenders on community supervision. Using these two rates for the different kinds of offenders in Washington, an estimated 25,000 offenders are in need of treatment.

Demand versus Treatment Capacity

Need is not equivalent to receipt of treatment. Some people are not amenable to being treated. The DASA data suggest that half of the people who are referred for treatment and determined eligible start treatment. If half of the offenders needing treatment were to enter treatment, then (based on our two methods of estimating demand) between 12,500 and 25,000 would enter treatment.

CURRENT CAPACITY OF PUBLICLY FUNDED TREATMENT PROGRAMS

The publicly funded substance abuse treatment system includes residential treatment (781 beds), outpatient treatment (2,366 slots) and prison-based chemical

dependency treatment (1,593 inmates per year). The residential and outpatient treatment is distributed across the state. Together these programs serve at minimum 16,648 clients per year. Since some clients are served by more than one program, this is not an unduplicated count. Outpatient services especially serve many clients whose treatment is partially provided by public funds, so the total number served is probably considerably larger. DASA data indicate 31,069 served in both types of programs. These findings are summarized in the following table.

ESTIMATED MINIMUM CAPACITY OF PUBLICLY FUNDED TREATMENT PROGRAMS

SERVICE	ESTIMATED MINIMUM CAPACITY	DURATION (DAYS)	ESTIMATED ANNUAL FTE ADMISSIONS
RESIDENTIAL SERVICES			
Intensive Inpatient	283	30	3,398
Recovery House	199	60	1,164
Extended Care	196	90	784
Long Term Resident - Drug	83	180	166
Long Term Resident - MICA	20	90	78
OUTPATIENT SERVICES			
Intensive Outpatient	184	90	737
Regular & ADATSA Outpatient	2,181	90	8,725
DOC PROGRAMS			
Prisons	1,197		1,197
Pre-release	396		396
TOTAL	4,739		16,645

BARRIERS TO SUFFICIENT TREATMENT FOR OFFENDERS

The national perspective on the barriers to substance abuse treatment suggests that the most significant barriers are too few resources and thus, too few treatment slots. Those are factors in Washington as well.

Additional important barriers are: doubts about treatment viability; difficulties in designing programs that identify appropriate offender clients, and which establish clear rules for behavior and have methods for enforcing rules quickly; and the lack of linkages

between the treatment and criminal justice systems, and between the inpatient and the outpatient portions of the two systems.

Concerns about treatment programs for offenders by both the treatment community and the criminal justice community also constitute barriers.

The treatment community asserts that criminal justice agencies refer clients who are not good candidates for treatment and expect the treatment agency to provide quasi-supervision. For this service, treatment agencies generally receive less than the actual cost of treatment.

Treatment providers further contend that the criminal justice system places clients who are too difficult to handle. Court ordered clients are seen as unwilling clients who have accepted treatment as a way to avoid jail.

These clients are seen as inappropriate in another way. Persons can be placed on deferred prosecution for two years. Yet ADATSA funded treatment cannot last longer than six months. Orders for treatment on deferred prosecution should take into account these limits on the duration of ADATSA funded treatment.

Funding is another contentious issue. The actual cost of treatment is often more than most offender clients can pay and the reimbursement rates from the public sector are also less than the actual cost. When available funding and true unit costs set the amount of treatment to be provided, then the level of treatment will be low -- perhaps too low to expect positive benefits except with the most motivated client. Most offenders do not fall into that group.

On the other side of the coin, the professionals in the criminal justice system often lack confidence in treatment alternatives or they see those alternatives as failing to meet other goals of the criminal justice system, e.g. to punish the offender for the offense or to deter future offenses committed by the offender or others. More specifically, they often do not recommend or order treatment because of delays in assessing the need for treatment and delays in admission to treatment.

The criminal justice professionals also note the absence of appropriate treatment, particularly for some types of offenders. Just as the treatment professionals are reluctant to take some offenders because they are too difficult to manage, the criminal justice professionals are reluctant to refer because the treatment does not seem sufficiently structured for some offender clients.

Finally, no barrier is as great as the one facing the offender who has a court order for treatment but who cannot pay for that treatment, or become eligible for public funding, or find an appropriate treatment to enter. Such an offender will often find him or herself serving a sentence in confinement even if s/he wanted to get into treatment.

COST OF PROVIDING TREATMENT SERVICES

Useful cost information about treatment services is only available for publicly funded services. This data actually reports reimbursement rates rather than costs. As such the data under-estimate the actual cost of treatment.

Based on available information, reimbursement rates by modality are as follows:

REIMBURSEMENT RATES BY TREATMENT MODALITY

TREATMENT MODALITY	DAILY RATE	DAYS	TOTAL RATE
INTENSIVE OUTPATIENT	14.17	90	1,275
REGULAR OUTPATIENT	8.33	90	750
INPATIENT	52.94	30	1,588
RECOVERY HOUSE	30.25	60	1,815
EXTENDED CARE DRUG RESIDENTIAL	42.96	180	7,733
EXTENDED CARE RECOVERY HOUSE (ALCOHOL)	24.97	90	2,247
MICA TREATMENT & DIAGNOSIS	75.07	30	2,252
MICA TREATMENT	75.07	90	6,756

Based upon what is known about offender utilization of treatment services, the average daily reimbursement rate for offenders (for all kinds of treatment) is just over $25 per day. On any given day about 47 percent of offenders in treatment are in some residential program. The remainder are in outpatient programs. (This does not mean that only 47 percent of offenders are ever in residential programs -- in fact, over 80 percent spend at least part of their treatment in a residential setting.)

Using these reimbursement rates, it is estimated that if half of the offenders needing treatment in 1991 actually entered treatment then the total annual cost of treatment for offenders would have been about $35.6 million. (As noted above, it is estimated that only half of all persons assessed as needing treatment actually enter treatment.)

IMPLICATIONS FOR THE FUTURE

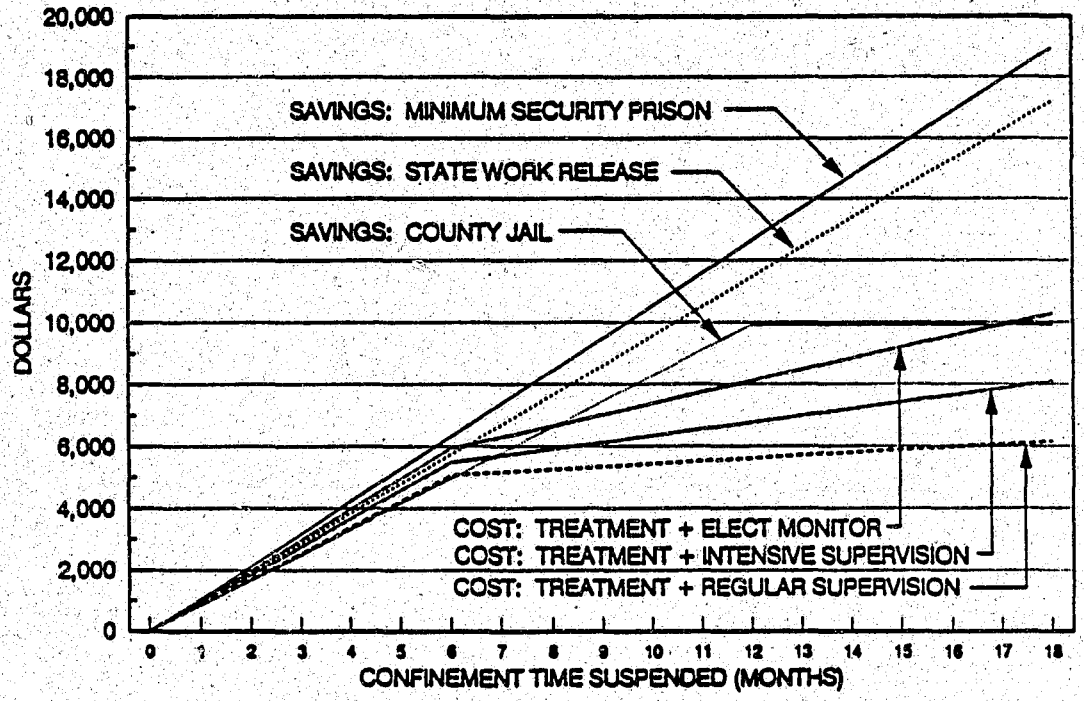
These same reimbursement rates can be used to estimate the cost of providing treatment to the additional offenders who are expected to enter the criminal justice system between now and 1996. Based on the projected number of offenders in 1996, it is estimated that the cost of treatment would exceed $55 million per year (in current dollars). The net increase due to projected growth in the offender population is about $20 million per year.

Since there is interest in some quarters to use substance abuse treatment as an alternative or supplement to traditional criminal sanctions for some offenders, the study also examined the cost implications of diverting offenders from confinement to treatment. Three scenarios were examined. (Note that these scenarios are not advanced as recommendations, rather as illustrations.)

The three scenarios involve diversion of offenders from jail, state work release, or minimum security prison to treatment plus various forms of non-incarcerative criminal justice control. Three forms of non-incarcerative control were examined: regular community supervision, intensive supervision, and electronic monitoring. Each scenario assumes that a full (180 day) course of treatment occurs and that current reimbursement rates continue.

Each of these alternatives has different costs. By comparing average daily costs for the three types of confinement to the cost of treatment plus the three types of non-incarcerative control, we can compare one to the other. What was found was that the cost of treatrnent plus regular supervision will always be less than the cost of even the least expensive form of confinement. Even the most expensive treatment alternative (treatment plus electronic monitoring) is less expensive than the least expensive confinement alternative (jail) if the diversion is for eight months or longer. The following graph illustrates comparative costs.

BREAKEVEN ANALYSIS
Cost & Savings Per Person
Assuming continued use of current treatment mix



The cost analysis also looked at the cost impact of treatment failures. The primary finding of this analysis was that the fiscal consequences of treatment failure are insignificant. For example, when the projected failure rate was changed from 30 percent to 50 percent, the largest change in the breakeven analysis was only 15 days.

Finally, we looked at the cost implications of increasing the number of offenders in residential programs. Currently about 80 percent of all offenders in treatment spend at least part of their treatment in a residential program. However, at any one time about 53 percent are in an outpatient program.

If we assume that all offenders spend at least some time in residential programs and that the time spent in residential programs is generally longer, we arrive at another set of circumstances. The assumptions used in this part of the analysis were: 1) all offenders start treatment in a residential program, and 2) at any given time about 70 percent of all offender patients would be in a residential program. Again, these assumptions are not advanced as recommendations but rather used for illustration.

Using these assumptions, the average daily reimbursement rate would increase from $25 to just over $33.

The breakeven analysis was repeated for this alternative set of assumptions. Using these assumptions, diversion of offenders from jail to higher cost treatment and high or moderate cost non-incarcerative control no longer makes financial sense. On the other hand, diversion of offenders from state work release or minimum security prison is financially attractive for even the most expensive treatment scenario for offenders who have their confinement sentences reduced by seven to eight months or more.

WASHINGTON'S PUBLICLY FUNDED TREATMENT SYSTEM

INTRODUCTION

In Washington, publicly and privately funded substance abuse treatment has several basic modalities. This section describes these modalities and the process by which clients enter them.

Ideally, clients pass from one treatment component to another in sequence. The usual first step is an assessment of treatment needs. Then there may be an inpatient treatment phase followed by an outpatient treatment period. Treatment may be very intensive at the beginning and become less intensive. There is often some type of long term follow-up or after-care.

Providers of substance abuse treatment services are certified by the Department of Social and Health Services Division of Alcohol and Substance Abuse. Some are for-profit, some are non-profit, others are run by local governments. Some providers are single individuals, others are businesses with multiple sites. The Department of Corrections contracts fr substance abuse treatment in 15 of its facilities.

Funds to run treatment agencies come from several sources. Across the country, the majority of clients are served by private, nonprofit agencies.[1] In 1987, the public sector in the United States treated 650,000 clients receiving revenues of $800 million, 80 percent of which were from public sources. Three-fourths of public sector programs were operated by not-for-profit providers of outpatient treatment. In the same year the private sector treated 200,000 clients from revenues of $500 million, 75 percent of which were from private sources.[2] Two-thirds of the private providers were hospitals.

In Washington, public funding of all kinds pays for just under half the treatment services available. Private third parties, i.e. insurance companies, and the clients themselves pay for the rest.

This report assumes that many Washington offender clients require publicly funded treatment, or they would be unable to comply with treatment orders. Thus, the focus of the material which follows is on the publicly funded segment of the treatment system in Washington state.

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[1] National Drug and Alcoholism Treatment Unit Survey (NDATUS): 1989 Main Findings Report, U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, 1990. The reporting rate for all states was 78 percent.

[2] Dean R. Gerstein and Lawrence S. Lewin, "Treating Drug Problems", New England Journal of Medicine, 9/20/90, pp. 844-848.

ACCESS TO PUBLICLY FUNDED TREATMENT

The Department of Community Development's grant application (FY 1991) to the Drug Control and System Improvement, Bureau of Justice Assistance acknowledged that Washington's publicly funded treatment facilities cannot care for those people who need and request drug treatment.[3] Although privately funded facilities in Washington may have sufficient capacity, many people cannot afford this care. DSHS' efforts to contract with these private providers is inhibited by the state's inability to pay for the full cost of private care.

In the community, ability to pay can restrict access to treatment. If the client is unable to pay in full by himself or through his insurance, he may ask if the agency has a sliding scale. One provider explained its scale as follows: $0 to $60 a month for low income clients, $120 a month for medium income clients, and $180 a month, top of scale.[4] Sliding scales are subsidized by full fees or by donations, such as from United Way. If reduced rates are still too high, the client can apply for public funds to pay for treatment.

The primary type of public funding for substance abuse treatment is ADATSA. In addition, there are several public third party funds, such as SSI and Title 19 (Medicaid)[5] Block grant funding to counties also pays for some treatment.

ADATSA is designed to provide "state financed treatment and support to indigent alcoholics and drug addicts."[6] Eligibility for ADATSA is defined by WAC and interpreted by staff of the Community Service Offices of DSHS.

> "Persons claiming incapacity based primarily on alcoholism or drug dependency shall be referred for evaluation under the alcoholism and drug addiction treatment and support program....Any general assistance recipient or applicant shall be required to undergo an alcohol/drug assessment if: the person claims an alcohol or drug problem or the department obtains medical or clinical evidence which indicates that within the last eighteen months such a problem appears to exist; or the department receives information that *the person has been arrested for an alcohol/drug related offense within the last ninety days....*"[7]

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[3] Washington State's 1991 Drug Control Strategy and Formula Grant Application, Fiscal Year 1991, Department of Community Development, 1991.

[4] Medjo, Jacqueline, The Use of Treatment Resources for Criminal Offenders in Selected Washington Counties, Washington Association of Prosecuting Attorneys, August 1991, p. 12.

[5] Medicaid, or Title 19, is the medical portion of the financial aid provided to persons on public assistance (SSI). The federal and state governments share the cost of Title 19.

[6] WAC 388-40-020

[7] WAC 388-37-135.

ADATSA applicants must meet the same financial eligibility requirements as GA-U applicants. They may have up to several hundred dollars in the bank, . They may even have a monthly income. However, some of that income is "disregarded" or excluded from the eligibility calculation. For example, the first $20 of a monthly social security check is disregarded. Once all "disregards" are set aside, then the department can require the remaining income in excess of the clothing and personal incidental standard be contributed "toward the cost of their care in a recovery house, extended care recovery house, or long-term care of drug residential treatment facility beginning the month following the month of admission...."[8] In practice this means that the low to no income individual (less than $339 a month with "disregards" subtracted) may have a few dollars each month for incidentals, and they will have all of their treatment covered. The modest income person (one who receives more than $339 after "disregards" are set aside, but whose income is less than the cost of inpatient treatment) may have a portion of his/her treatment paid. The higher income person will have no portion of his/her treatment paid.

GA-U or General Assistance Unemployable is a state program which provides assistance to persons who are incapable of maintaining employment. "Persons who are unemployable due to alcohol or drug addiction are generally not eligible for general assistance."[9] There are persons who are eligible for both GA-U and ADATSA. They must participate in ADATSA treatment "when it can be reasonably expected to enable the person to work or to reduce the need for assistance...."[10]

Some persons addicted to alcohol or drugs are sufficiently impaired by that addiction or another condition that they are eligible for Supplemental Security Income (SSI). SSI eligibility is determined by staff of the Disabilities Determination Unit, Social Security Administration.

The standards for SSI eligibility are specific and difficult to meet. Only the most disabled with the longest (unable to work for 12 months or more), most chronic histories of disability obtain that support. Social Security staff take up to three months to process the requests for assistance and require careful documentation. ADATSA regulations require those potentially able to qualify to apply for SSI. Many disabled persons wait out their SSI processing while on GA-U.

For those who are not eligible for assistance from any of these funds, but who have insufficient funds to pay for their treatment, the publicly funded options are limited to those that are available through the block grants made to counties. Block grants are designed to provide basic services to the "working poor", and are not tied to narrow eligibility requirements for disability, such as those found with ADATSA or public third party funds. These funds (which flow from the state to the county to the provider) are used to buy whatever the state and then the county planning bodies deem necessary

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[8] WAC 388-40-040 (3).

[9] WAC 388-37-010 specifies the termination of General Assistance (GA-U).

[10] WAC 338-37-135.

to meet the needs of client groups who are unable to qualify for other public paid programs. A typical decision is to purchase treatment services from the county's providers for special emphasis populations although this is not always the situation. In King County, for example, the block grant funds have gone primarily to pay the costs of running the detox center.

The state has identified the following populations for special emphasis: "pregnant women and new mothers, families with dependent children, recipients of child welfare and child protective services, adolescents, ethnic minorities, *criminal justice system referrals*, IV drug users, people with AIDS, people with traumatic brain injury, people with cognitive disorders, and handicapped people."[11] Planning bodies in individual counties may further specify populations to be served.

Offenders sentenced to prison are assessed for substance abuse while in reception. Those with identified substance abuse treatment needs and those who have a court order for substance abuse treatment are scheduled for substance abuse treatment during their imprisonment. DOC staff indicate that inmates with court ordered treatment are given priority in their programs. Few jails offer substance abuse treatment other than access to self-help groups, such as AA and NA.

PUBLICLY FUNDED TREATMENT MODALITIES IN THE COMMUNITY

The DSHS Community Service Office is the entry point for publicly funded, community based substance abuse treatment under ADATSA. If a person's eligibility is verified, s/he is referred to a chemical dependency assessment center, where s/he is interviewed by a trained counselor who determines to what degree the person is addicted and what treatment modality is appropriate. If the person is an offender, the counselor will make recommendation to the judge who issued the original sentence. The judge may then order treatment.

The majority of clients not eligible for ADATSA funded services are assessed by the agency that provides the treatment services, whether outpatient or inpatient. This practice varies from county to county as there may be a specific agency that only provides assessments in some places. One county coordinator told us that he estimated 70 percent of his non-ADATSA clients were court referred by diversion from a DWI citation.

There are two types of assessments: DWI assessment and the full drug and alcohol assessment. These may or may not be performed by the same counselor, but they are performed in the same setting. A DWI assessment followed by alcohol information school is the least restrictive treatment path. A drug/alcohol assessment followed by intensive inpatient treatment, recovery house, and outpatient treatment is the most restrictive path. Regardless of the treatment(s) needed, a person may receive

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[11] Division of Alcohol and Substance Abuse, Program Description, 1990.

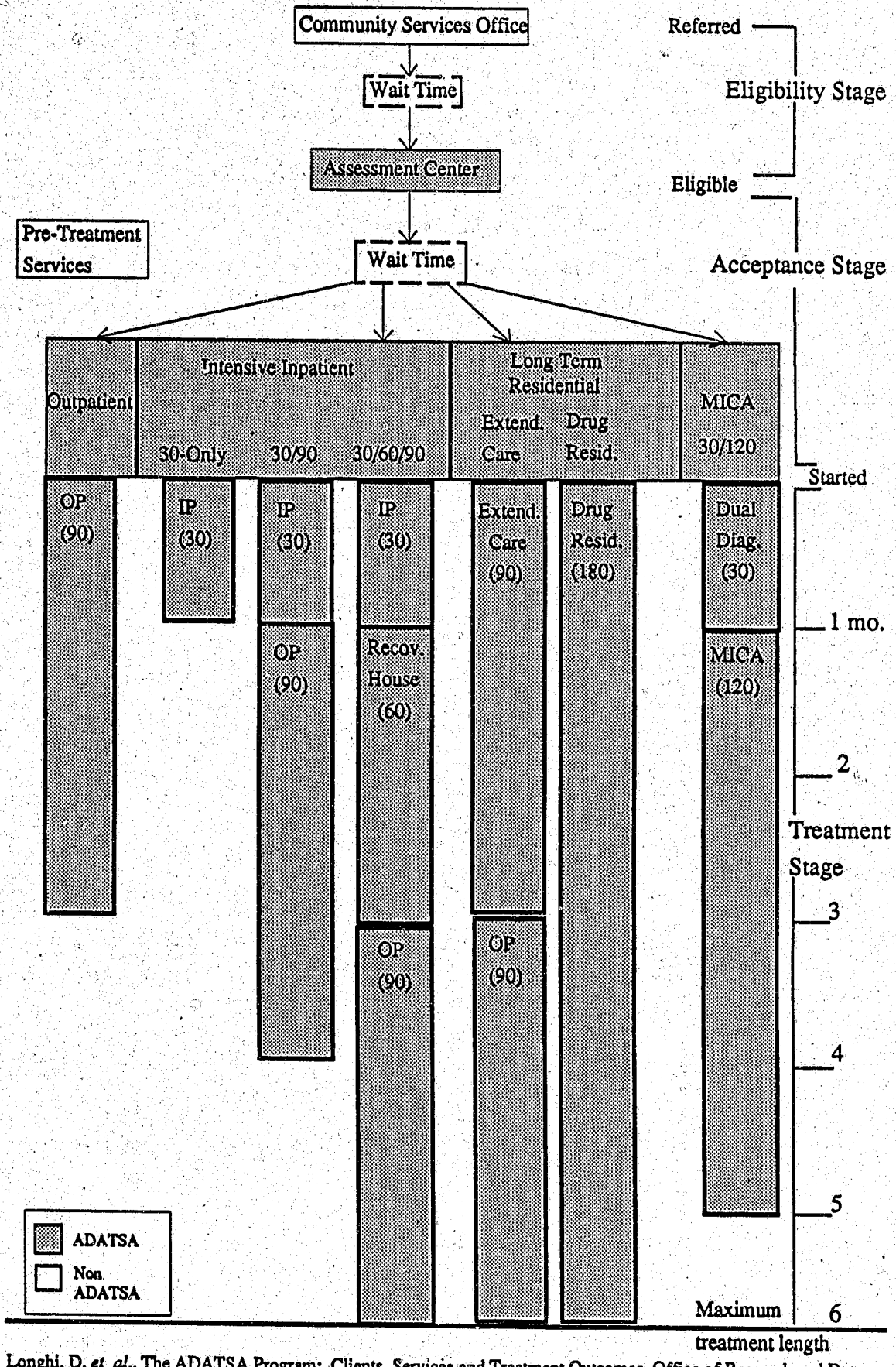
no more than 180 days of services (including detoxification) within a 24 month period under DASA.

The chart on the following page shows various combinations of treatment modalities, or paths for ADATSA treatment. We are indebted to Dario Longhi of DSHS' Office of Research and Data Analysis for its use.[12]

[12] Longhi, D. *et al.*, The ADATSA Program: Clients, Services and Treatment Outcomes, Office of Research and Data Analysis, Department of Social and Health Services, Olympia, Washington, December 1991, Report 4-17, Page 6.

TABLE 1

Eligibility, Acceptance, and Treatment Phases for ADATSA Clients, and Treatment Paths Funded



Longhi, D. *et al.*, The ADATSA Program: Clients, Services and Treatment Outcomes, Office of Research and Data Analysis, Department of Social and Health Services, Olympia. Washington, December 1991, Report 4-17, Page 6.

The Washington Administrative Code is quite specific about the publicly funded services that are available to substance abusers. Chapter 275-19 (Alcohol and Drug Treatment Facilities) and Chapter 388-40 (Alcohol/Drug Programs) detail the services. These services include assessment, detoxification, inpatient (of varying intensities) and outpatient (regular and intensive) services. The material which follows is taken directly from those WAC chapters.

ASSESSMENT SERVICES

DWI Client Assessment Services

DWI client assessments may be performed by a certified counselor working within a chemical dependency assessment center, or by a certified counselor working for a district court probation agency. Five probation agencies (King County, Bellevue Municipal, Seattle Municipal, Kitsap County and Pierce County) were identified through the 1991 Capacity Study as having people trained to perform assessments (certified drug/alcohol counselors).

DWI assessments include the following services: administration of a written screening instrument using, as a minimum, the Washington alcohol screening inventory; an evaluation of client's blood alcohol and/or drug level when arrested for alcohol/drug related offense; an evaluation of client's report of his/her driving record; treatment recommendations if the person has an alcohol or drug problem which requires treatment, or referral of the client to information school if the person requires only alcohol and drug education.[13]

Chemical Dependency Assessment Services

Chemical dependency assessment centers are contract agencies of the Department of Social and Health Services, Division of Alcohol and Substance Abuse, who provide the following services:

(1) An alcohol and drug assessment of all clients providing, at a minimum, the following:
   (a) A diagnostic interview with a qualified counselor, as defined in WAC 275-19-145, gathering at a minimum, the information required on an ADATSA assessment form approved by DASA;
   (b) The counselor's written assessment concerning the client's diagnosis of alcoholism or drug addiction and whether or not the client is incapacitated as a result;
   (c) A record of the outcome of the assessment interview with the client, indicating the decisions reached by the counselor as to the treatment and shelter plan the client is to follow;

[13] WAC 275-19-770.

(2) A preliminary screening of clients and referral of those clients qualifying for social security supplemental income or general assistance-unemployable benefits based on mental illness or physical disability to the department's local community services office.

(3) Case supervision of treatment and/or shelter services for clients admitted to the ADATSA program.[14]

FACILITY BASED (RESIDENTIAL) SERVICES

Following an alcohol and drug assessment a patient may move to inpatient services or to outpatient services. In all cases the maximum time under ADATSA during which treatment can occur is 180 days.

If the person needs inpatient services, s/he generally will receive either intensive inpatient treatment services or long term residential services or, if mentally ill, services specific to mentally ill chemical abusers (MICA).

There are several options that may follow a 30 day course of intensive inpatient services: the person may be discharged with recommendations for after-care, such as AA or NA or CA; the person may be referred to outpatient treatment for 90 days; or the person may be referred to a recovery house for 60 days, then to outpatient treatment for 90 days.

Intensive Inpatient Treatment Services

These services provide a concentrated residential program consisting of a combination of education, individual therapy, group therapy, and related activities to detoxified alcoholics and detoxified addicts. These programs are required to have an organized program and staff sufficient to educate clients regarding alcohol and drug addiction, provide intensive individual and group counseling at least 20 hours per week per client, provide social and recreation activities, provide after-care planning, provide discharge and referral to necessary supportive organizations and agencies, invite and encourage family members to participate in their own treatment program (such as family counseling, Alanon, Naranon, Alateen) and to participate in the client's treatment.[15]

Recovery House Services

These services provide care and treatment in a residential setting with social and recreational activities for detoxified alcoholics and detoxified addicts to aid their adjustment to abstinence and aid their engagement in occupational training, gainful employment, or other types of community activities. There shall be an organized program and staff sufficient to provide four and one-half hours of counseling service per

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[14] WAC 275-19-590

[15] WAC 275-19-320

week per client; vocational services to assist clients in finding employment; and referral to necessary supportive organizations and agencies.[16] Although not specified in WAC, recovery house services are generally for 60 days.

Another treatment path is available for more seriously disabled substance abusers: long term residential treatment. This program has two modalities: extended care (for both alcohol and drug abusers) and drug residential (for drug abusers). Extended care is a 90 day inpatient program, which may be followed by 90 days of outpatient services, or another 90 days of inpatient treatment. Drug residential care is a 180 day program, which includes the publicly funded outpatient services. These programs are the only traditional therapeutic community programs available to public pay clients in Washington.

Extended Care Recovery House Services

These services provide care and treatment for detoxified alcoholics and detoxified addicts needing prolonged treatment services in a residential setting in excess of sixty days. These programs are required to have an organized program and staff sufficient to provide client care and treatment for more than 60 days; to provide four and one-half hours of treatment services per week, including education regarding living sober and drug-free and individual and/or group counseling; to provide vocational services to assist client in finding employment; and to provide referral to necessary supportive organizations and agencies.[17]

Long-Term Treatment Services

These services provide care and treatment on a long-term basis, 90 days or more, in a residential setting with personal care services for chronic alcoholics and drug addicts with impaired self-maintenance capabilities needing personal guidance and assistance to maintain abstinence and good health under, or in lieu of, the involuntary commitment law.[18] Such programs are required to provide an organized program and staff sufficient to provide education of clients regarding alcohol and drug addiction; individual and group counseling; education concerning social and life-coping skills; social and recreational activities; assistance in finding employment when appropriate; after-care planning; discharge referral to necessary supportive organizations and agencies.[19]

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[16] WAC 275-19-530

[17] WAC 275-19-570

[18] Chapter 70.96A RCW

[19] WAC 275-19-430

COMMUNITY BASED SERVICES

For DWI or alcohol and drug patients, the other route from assessment is to outpatient services. There are several options here: alcohol/drug information school, intensive outpatient, regular outpatient and ADATSA outpatient services, and/or methadone treatment services. But the maximum length during which treatment may occur is the same: 180 days.

People referred to outpatient services are generally those with stable living situations, whose dependency on drugs or alcohol is less severe than those referred directly to a facility based service. We were told that some agencies may "hold" clients in outpatient treatment waiting for a inpatient bed to become available.

Information School

Information school is an eight to 15 hour educational program that instructs students about the use and abuse of alcohol and other drugs. Its goal is to help persons not currently presenting a significant chemical dependency problem make informed decisions about the use of alcohol and other drugs.

Information school topics include the content and objectives contained in "An Instructor's Guide to Alcohol and Other Drugs Information School", published in 1986, as amended and a test from the same manual administered to each enrolled student at the course completion.

Outpatient Treatment Services

Outpatient treatment services provide alcoholism, drug addiction, alcohol and drug abuse treatment services according to a prescribed plan in a nonresidential setting. Outpatient treatement services provide an organized program and staff sufficient to provide assessment of the client's needs regarding specific alcohol or drug related problems; referral to treatment and ancillary facilities for services consistent with assessment; individual and group counseling; education on alcohol and drugs; and discharge and referral to necessary supportive organizations and agencies.[20]

One provider described its treatment schedule as 1.5 hours of group counseling per week, and 15 minutes of face to face (individual) counseling per month. This would total 18.75 hours over 90 days.

ADATSA Outpatient Treatment Services

ADATSA outpatient treatment service is defined as an organized program and staff sufficient to provide counseling services focused on assisting clients to avoid relapse; counseling services assisting clients in preparation for and obtaining employment; assistance to clients in developing living skills necessary for independent

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[20] WAC 275-19-610

living; assistance to clients in obtaining housing and basic provision conducive to ongoing recovery.[21]

The ADATSA outpatient services go beyond the outpatient services previously described to include a specific mandate to help clients prepare for employment, develop independent living skills and obtain housing.

Intensive Outpatient Services

Intensive outpatient services provide a concentrated, nonresidential program consisting of a combination of educational sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and detoxified addicts and their families. Intensive outpatient services provide an organized program and staff sufficient to provide assessment of the client's needs regarding specific alcohol and drug related problems; 72 hours of treatment services within 12 weeks (including group and individual counseling sessions); education regarding alcohol and drug addiction; group therapy sessions; and referral to structured after-care program after completion of treatment.[22]

One provider outlined its treatment schedule for clients on misdemeanor deferred prosecution as follows. During the first 90 days, six hours of group counseling are required each week and one face-to-face (individual) session for each 20 hours of group. During the next 26 weeks, 1.5 hours of group counseling per week are required and face-to-face sessions are at the request of the counselor or client. During the next 15 months, 1.5 hours of group counseling are required, and face to face (individual) sessions are at the counselor's or client's request. Note: this is 24 months altogether, (as required for deferred prosecution) and exceeds the period that ADATSA funds by 18 months.

Methadone Treatment Services

Methadone treatment services consist of a series of treatment requirements in the following areas: intake, urinalysis, detoxification, dispensary, counseling, and take-home medication.

Intake treatment requirements include a physical by a program physician or other appropriately licensed health professional, a diagnosis of current physiological dependence on an opiate drug, and an overall health evaluation.[23]

Urinalysis treatment requirements include a monthly urine sample (if a person has had positive urine a twice monthly urine sample is required); random sampling; required

[21] WAC 275-19-680

[22] WAC 275-19-660

[23] WAC 275-19-940

screens; mandatory discharge for three consecutive positive urines; and mandatory discharge for absence of methadone.[24]

Detoxification treatment requirements include planned detoxification dates with written criteria for each client.[25] Dates are to be set within 90 days of admission. Dispensary operational requirements include dispensary staffing, methadone handling procedures, methadone stock inventory, and quantitative analysis.[26]

Counseling treatment requirements include individual (thirty minutes per week for the first ninety days) and group (forty-five minutes per week for the first ninety days) counseling for each client to accomplish treatment plan goals and objectives. Counseling may be reduced to two sessions per month in the next six months, and one per month thereafter. A counselor/patient ratio of one qualified counselor (FTE) to fifty patients is required.[27]

Take-home medication requirements include provisions for all patients to take home a one-day dosage and for stabilized patients (who have been receiving methadone for at least ninety days and who have had negative urines for the past sixty days) to take home a two-day dosage. Patients who have two positive urines in the last ninety days lose take-home privileges.[28]

TREATMENT FUNDED BY DOC - WITHIN INSTITUTIONS

The Department of Corrections provides substance abuse treatment through designated contractors in fifteen of its facilities. The contractors provide each participant 91 hours of intensive outpatient treatment programs. Spanish speaking treatment counselors are available in selected sites.

Included are training and education in stress management; anger management; problem solving; goal setting; assertiveness; communications; Adult Children Of Alcoholics issues; family dynamics; drug/alcohol information; progression of addiction; recovery; sexuality; AIDS education; grief and loss; nutrition; relapse prevention and spirituality. Also included within this time frame are 27 hours of group counseling on after-care life skill issues, four hours individual counseling, and five AA, NA, or CA meetings.

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[24] WAC 275-19-950

[25] WAC 275-19-960

[26] WAC 275-19-970

[27] WAC 275-19-980

[28] WAC 275-19-985

Two contractors provide all services. One contractor provides services to the Washington State Reformatory, WSR Farm, Indian Ridge Corrections Center, Olympic Corrections Center, Clallam Bay Corrections Center, Twin Rivers Corrections Center, Eastern Washington Pre-Release, Pine Lodge Corrections Center, and the Washington State Penitentiary. Another contractor serves the remaining facilities: Larch Corrections Center, Cedar Creek Corrections Center, McNeil Island Corrections Center, Washington Corrections Center, Washington Corrections Center for Women, and Tacoma Pre-Release.

TREATMENT FUNDED BY DOC - IN COMMUNITY BASED PROGRAMS

In community-based programs the Department of Corrections provides a combination of chemical dependency programs for offenders in partial confinement at four facilities. These offenders are work releasees resident in DOC or contract facilities, who have a history of chemical dependency, who are not in relapse, but who may benefit from weekly workshops designed to reinforce relapse prevention and provide referral to community resources. The program serves as an after-care component for those inmates who have completed a DOC institution-based program and/or those who need counseling to help avoid failing in work release as a result of chemical dependency.

Contractors provide residents who have a history of chemical dependency with a 45 day open-entry/exit program. Each resident receives two sessions of individual counseling at least one hour long, and 1.5 hours of group process or education per week. Reading and writing assignments are mandatory, as well as participation in AA or NA on an individually determined basis.

Community based programs are offered at Ratcliff (Seattle), Reynolds (Seattle), Yakima, and Cornelius (Spokane) Work Release Centers.

SUMMARY

Public funds, of any kind, pay for slightly less than half the treatment services available in Washington. ADATSA funds provide slightly more than 15 percent of publicly funded services.

The services outlined from the Washington Administrative Code cover the range of treatment services that is available through public funds in Washington. These include assessment (DWI and alcohol/drug), alcohol/drug information school, outpatient (intensive, regular and ADATSA), methadone treatment, intensive inpatient, recovery house, extended care recovery house, and long term treatment services.

After clients are screened, they may be evaluated through one of two assessments: DWI assessment or alcohol/drug assessment. Other publicly funded

clients may be screened and assessed by the agency that will provide outpatient or inpatient services.

Following assessment, a qualified counselor will recommend one or a combination of the following treatment paths for the client.

1. Alcohol/drug school for 8 to 15 hours of instruction.
2. Regular outpatient service for 90 days.
3. Intensive outpatient services for 90 days.
4. Intensive inpatient service for 30 days.
5. Intensive inpatient service for 30 days, then to outpatient service for 90 days.
6. Intensive inpatient service, then to a recovery house for 60 days, then to outpatient service for 90 days.
7. Extended care residential services for 90 days, then to outpatient service for 90 days.
8. Drug residential service for 180 days.
9. For MICA: to MICA residential treatment for 30 days, then to dual diagnosis residential treatment for 90 days.

Publicly funded treatment is limited to 180 days within a 24 month period. A client may move in and out of various treatment modalities, but can only receive treatment during a six month period. Except for 180-day inpatient programs, the maximum amount of treatment received is substantially less than six months.

The Department of Corrections contracts for substance abuse treatment services in 15 of its institutions and four work release centers. They give priority to inmates with court orders for treatment.

TREATMENT EFFECTIVENESS

INTRODUCTION

This section of the report provides an overview of the literature concerning substance abuse treatment and outcomes. There is extensive literature on substance abuse treatment for offenders, its effectiveness, and the program attributes that distinguish effective treatment. Several longitudinal studies have followed large numbers of clients through treatment. Others have assessed specific treatment programs, including several in Washington.

Most work in this field distinguishes between treatment for drugs (opiate, non-opiate) and treatment for alcohol abusers (DWI and other offenders). The drug assessment literature is largely focused on the treatment of heroin and cocaine abusers, including the polydrug abusers who also abuse alcohol.

There is a sizeable literature concerning treatment for opiate (heroin) addiction. There has been much less emphasis on treatment for cocaine addiction, including crack, because cocaine addiction has only recently been recognized as a significant social problem. Other specific addictions, such as those for methamphetamines or inhalants, have received less attention except in large scale surveys of treatment outcomes.

OVERVIEW OF STUDIES

The substance abuse treatment field has been the subject of several major efforts to assess the effectiveness of their activities. These studies include several major surveys of client outcomes by modality, sophisticated re-analysis of smaller program evaluations, and continuing evaluations of specific programs. In Washington there have been several studies of outcomes for clients of publicly funded treatment.

National Surveys of Client Outcomes

Two major surveys of drug treatment programs and client outcomes have published results. The first survey results were from Drug Abuse Reporting Programs (DARP) conducted from 1969 to 1974.[29] The second results were from Treatment

[29] S.B. Sells and D. D. Simpson, eds., "The Effectiveness of Drug Abuse Treatment", Further Studies of Drug Users, Treatment Typologies, and Assessment of Outcomes During Treatment in the DARP, 1976, Additional material was released in 1977 and 1979.

Outcome Prospective Study (TOPS) conducted from 1978 to 1981.[30] Another survey called DATOS or Drug Abuse Treatment Outcome Study is scheduled for this decade.

TOPS followed over 10,000 drug users. While nearly half used alcohol regularly (weekly or daily) in the year before admission to treatment, they were primarily dependent on an illicit drug, and their treatment focused on the latter drug use. Seventy percent or more used two or more drugs. TOPS assessed treatment received in 37 programs across the country. One cohort was in methadone maintenance, another in intensive residential programs (mostly in therapeutic communities), and a third in drug-free outpatient treatment. A sample from each cohort was interviewed more than once following treatment. Treatment outcome data were collected on re-admission, commission of predatory crimes, employment, depression, drug use, and alcohol use. The TOPS research team concluded that treatment for substance abuse was effective.

Re-analysis of Previous Evaluations

The best known re-assessment of previous evaluations of correctional treatment is that done by Robert Martinson and colleagues.[31] They reviewed evaluations which met basic scientific principles for testing hypotheses and found that rehabilitation programs had no significant effect on recidivism. In a later review, the National Academy of Science also concluded that correctional treatment does not work.[32] Other scholars have challenged those findings.[33]

A recent re-analysis focused on specific types of treatment and their effect on recidivism.[34] Andrews and colleagues reviewed 45 studies of juvenile and 35 studies of adult correctional treatment programs. They found that "appropriate" correctional treatment did have a positive effect on recidivism. Appropriate treatment was defined as a "firm but fair" approach, modeling and reinforcement of noncriminal behavior, and problem solving and skill training.

Re-analysis of substance abuse treatment evaluations has been more positive. M. D. Anglin of the Drug Abuse Research Group at the University of Southern California at Los Angeles is perhaps the most consistent reviewer of this literature.

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[30] R. L. Hubbard, M. E. Marsden, J. V. Rachal, H. J. Harwood, E. R. Cavanaugh, and H. M. Ginzburg, Drug Abuse Treatment: A National Study of Effectiveness, University of North Carolina Press, 1989.

[31] R. Martinson, "What works? Questions and answers about prison reform", The Public Interest 35: 22-54, 1974.

[32] L. Sechrest, S.O. White and E. D. Brown, The Rehabilitation of Criminal Offenders: Problem and Prospects, National Academy Press, Washington, DC, 1979.

[33] T. Palmer, "Martinson revisited", Journal of Research in Crime and Delinquency 12: 133-152, 1975.

[34] D.A. Andrews, I. Zinger, R.D. Hoge, J. Bonta, P. Gendreau, and F.T. Cullen, "Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis", Criminology, 1990.

Anglin and Hser published a review of program assessments in Tonry and Wilson's Drugs and Crime.[35] They focused on drug abuse rather than alcohol abuse, on methadone maintenance, residential treatment (as in therapeutic communities), and drug free outpatient treatment. They also looked at civil commitment programs for drug addicts. In this piece Anglin and Hser were particularly concerned with the offender in drug treatment. They concluded that methadone maintenance and therapeutic community programs were effective with offenders.

Chaiken reviewed four model prison-based programs for felony offenders:[36] Cornerstone Program operated by the Oregon Department of Human Resources, Corrections and Mental Health Divisions at the Oregon Mental Hospital; Lantana Program in Florida operated by the Lantana Hospital at a medium security institution; Simon Fraser University Prison Education Program operated by the Prison Education Program in the Department of Continuing Education and housed in several institutions; and Stay'N Out Program operated by the New York Therapeutic Communities at a medium security institution.

Outcomes varied from program to program. The Simon Fraser Program reported half of its control group returned to prison within three years, but only 16 percent of its treatment group went back. Twenty-nine percent of the Cornerstone participants returned to prison within three years. This compared favorably with Cornerstone dropouts who had a recidivism rate of 74 percent and with Oregon parolees who had a rate of 37 percent. Lantana did not have a comparison group. In 1983, the recidivism rate for participants paroled after 1977 was 18 percent.

Stay'N Out compared those selected to participate with those who had been selected, but for administrative reasons did not participate. The participants again did better than the non-participants, 27 percent of the program's participants were re-arrested as opposed to 41 percent of the nonparticipants. A more recent follow-up study shows Stay'N Out participants who stayed nine months to a year did better than those who left sooner.

The National Academy of Science Institute of Medicine compiled findings from a series of studies on the effectiveness of drug treatment.[37] They concluded that methadone maintenance programs have a positive effect on the behavior of persons dependent on opiates, that therapeutic communities have a positive effect on the behavior of drug dependent persons (those primarily dependent on heroin and cocaine), and that outcomes for outpatient treatment are positively related to the length of treatment. Positive outcomes include reductions in criminal behavior.

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[35] M. Douglas Anglin and Yih-Ing Hser, "Treatment of Drug Abuse", Drugs and Crime, Volume 13, University of Chicago Press, 1990.

[36] Marcia R. Chaiken, In-Prison Programs for Drug-Involved Offenders, National Institute of Justice, UW Department of Justice, July 1989.

[37] Gerstein and Lewin, Op.cit.

The National Institute of Alcohol Abuse and Alcoholism did a similar review of alcoholism treatment studies.[38] A peer review panel selected work done between 1976 and mid-1984 which met accepted scientific requirements for testing hypotheses, such as random assignments and controls. They concluded that clients were improved and that those who received sufficient treatment did better than those who received minimal treatment.

This is despite evidence, also cited in the NIAAA assessment research, that alcoholics can alter their drinking habits with little or no treatment; perhaps 40 or 50 percent do. Although they have more chance of ceasing to drink or of controlling their drinking with treatment, both Emrick[39] and Armor[40] found that treatment may only add another 20 percent to success rates.

Longer follow-up studies show that significant numbers return to their former drinking behavior; perhaps 26 percent of the treated group and 19 percent of the untreated group remain improved after one year.[41]

Washington State Surveys of Client Outcomes

There are three recent assessments of outcomes for substance abuse treatment programs in Washington. The Department of Corrections evaluated its in-prison program in the middle eighties and is redoing that evaluation now. The DSHS Office of Research and Data Analysis, in cooperation with DASA, completed an assessment of ADATSA services last fall. A University of Washington faculty member, acting at the behest of DASA, just completed an analysis of all persons discharged from publicly funded treatment during the last quarter of 1990.

DOC Substance Abuse Treatment in Prison

In 1984, DOC initiated substance abuse treatment within prisons. Treatment agencies, certified by DASA, were retained on contract to provide outpatient services.

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[38] Dan J. Lettieri, Mollie A. Sayers and Jack E. Nelson, eds; Summaries of Alcoholism Treatment Assessment Research; National Institute on Alcohol Abuse and Alcoholism, Rockville, MD, 1985.

[39] C. D. Emrick, "The relative effectiveness of different treatment approaches and the effectiveness of treatment versus no treatment", Journal of Studies on Alcohol, 36-1:88-108, 1975.

[40] D.J. Armor, J. M. Polich, and H. B. Stambul, Alcoholism and Treatment, RAND, Santa Monica, CA, 1976.

[41] W. R. Miller and R.K. Hester, "Treating the problem drinker: Modern approaches", The Addictive Behaviors,: Treatment of Alcoholism, Drug Abuse, Smoking and Obesity, Pergamon, Oxford, 1980, pp 11-141.

DOC assessed the treatment in two parts. The first, in 1986, looked at the treatment itself and the completion rate,[42] which ranged from 64 to 84 percent. This was much higher than the initial expectation of 20 percent completion. Completion rates have remained high through 1991. In 1988, the second phase of the assessment considered the effect of substance abuse treatment on infractions while within the institutional system and the effect on return to prison.[43] The assessment was to include the effect on substance abuse infractions, but that effect was confounded by the introduction of drug testing after the treatment program began. Program participants had a significant decrease in non-substance abuse infractions. They were significantly less likely to return to prison within the two years that they were followed. The study found that they were as likely to recidivate in the first year, but less likely to do so after the first year.

Outcome for ADATSA Treatment

A 1989 study[44] of ADATSA-funded Washington clients found that long waits for assessment (21 days on average) and for treatment (20 days on average) had a significant negative effect on treatment participation. Thirty percent dropped out between referral and assessment. Of those assessed as accepted for treatment, 23 percent dropped out before entering treatment. The longer the delays the more potential clients dropped out of the process. A week's wait to enter treatment resulted in about 13 percent of the clients not appearing, while a wait of three months resulted in as many as 70 percent of the clients not appearing.

Different modalities had significantly different delays. Outpatient treatment was the easiest to enter; the average (median) wait was nine days. Extended care (90 day treatment) had the longest delays, averaging 45 days.

With the exception of residential drug treatment, almost half of the ADATSA clients finished the treatment regime prescribed for them. Older clients, those with some prior treatment and those who were dependent on alcohol only, were more likely to complete treatment. Persons who had been charged, at some time, for driving under the influence, were also more likely to complete treatment.

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[42] J. Hall-Milligan, R.P. Smith, W. White, L. Howell, C. Dizon, and T. Guerin, Substance Abuse Treatment: Program Evaluation Office of Program Development, Department of Corrections, Olympia WA, 1986.

[43] J. Hall-Milligan, R.P. Smith, W. White, L. Howell, C. Dizon, and T. Guerin, Substance Abuse Treatment Program: Evaluation of Outcomes and Management Report, Division of Management and Budget, Planning and Research Section, Department of Corrections, Olympia WA, 1988.

[44] Longhi, Op.cit.

Outcomes for All DASA Funded Treatment

A recently completed study reviewed treatment and treatment outcomes for all DASA clients.[45] This assessment of treatment outcomes considered all persons discharged by publicly funded treatment during the last quarter of 1990. The cohort included persons whose treatment was fully funded by DASA, such as the ADATSA population described above, and those whose treatment was only partly funded by DASA. DASA funding included that which was administered through the counties.

The authors assessed outcomes for all modalities, including types of residential treatment. The data were drawn from client reports submitted to DASA by providers of treatment. Client characteristics, referral sources, primary drug use, modality, and completion rate were all included. Data was not collected on outcomes other than completion of treatment, and were not included in this assessment. The results of this study, including information on completion rates, are reported in conjunction with modality information in the later chapters.

GENERIC OUTCOMES

Some outcomes reviewed below are for alcohol treatment or for drug treatment, and some are for offenders in treatment. Other findings refer to specific treatment modalities.

Outcomes for Alcohol Treatment

Alcohol treatment outcomes are less definitive than those for drug treatment. Many treatment variations have developed, complicating the assessment of their effects, and controlled studies have produced mixed results.[46]

Several of the studies reviewed by the NIAAA assessed modalities and their effectiveness in treating the alcoholic. Medication was found to have no effect on drinking behavior. Miller and Hester found only some aversion therapies, specifically nausea-inducing and verbal aversion, that appear to have more positive outcomes than no treatment. They also report that these therapies may have other negative effects.

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[45] Thomas Wickizer and Charles Maynard, Analysis of Completion Rates of Clients Discharged from Drug and Alcohol Treatment Programs in Washington State, Division of Alcohol and Substance Abuse, Department of Social and Health Services, Olympia WA, 1992.

[46] L. Saxe, D. Dougherty, K. Esty, and M. Fine, Health Technology Case Study 22: The Effectiveness and Costs of Alcoholism Treatment; Congress of the United States, Office of Technology Assessment, Washington, D.C., 1983; and A.T. McLellan, L. Luborsky, G. E. Woody, C.P. O'Brien, and K.A. Druley; "Predicting response to alcohol and drug abuse treatments", Archives of General Psychiatry, 40:620-625, 1983.

Other forms of therapy have shown mixed results. To some it appears that any form of therapy, any form of treatment, may have positive effects. However, most agree that the number of controlled tests are too limited to reach definitive conclusions.[47]

There is some evidence to suggest that there may be a relationship between type of alcoholic and successful intervention by a specific type of treatment. For example, the few controlled studies of Alcoholics Anonymous suggest that it benefits some alcoholics more than others. One study found education as a stand alone program is not effective with chronic alcoholics.[48] Others have found that extensive, long-term programs are no more effective than less expensive, shorter approaches, except perhaps for a select and small group of alcoholics.[49] Sannibale found there is some evidence that persons with lesser alcohol problems improve in any program, those with moderate problems do better in some programs, and those with severe problems require intensive residential treatment.[50] All appear to benefit from after-care. Emrick found that compulsory outpatient treatment for chronic municipal court offenders has no greater impact than no or voluntary treatment. The impact is greater if it is combined with increased penalties for failure to participate.[51]

Perhaps the primary conclusion of these studies is that matching clients with treatment shows promise of improvement in outcomes.[52]

Outcomes for Drug Treatment

The TOPS survey (1978-1981) of client outcomes of 37 programs found that treatment was followed by a reduction in substance use (other than marijuana and alcohol), a reduction in predatory crimes to 33 to 50 percent of pretreatment levels, and

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[47] C.D. Emrick, "Evaluation of alcoholism psychotherapy methods", Encyclopedic Handbook of Alcoholism, E. M. Pattison and E. Kaufman, eds., Gardner Press, New York, 1982, pp. 1152-1169.
Armor, Polich and Stambul, Op.cit.

[48] A. Alterman, J. M. Holaha, T. G. Baughman, and S. Michels, "Predictors of Alcoholics' Acquisition of Treatment-Related Knowledge", Journal of Substance Abuse Treatment, 6:1989, pp. 49-53.

[49] Miller and Hester, Op.cit.

[50] Claudia Sannibale, "A prospective study of treatment outcomes with a group of male problem drinkers", Journal of Studies on Alcohol, 50(3), 1989.

[51] Emrick, Op.cit.

[52] A. McLellan, G.E. Woody, L. Luborsky, C.P. O'Brien, and K.A. Druley, "Increased effectiveness of substance abuse treatment: A prospective study of patient-treatment "matching", Journal of Nervous and Mental Disease, 171(10):597-605, 1983.

an improvement in rates of employment.[53]The earlier DARP survey found arrest rates decreased by 74 percent following treatment.[54]

Daily heroin use among a group of clients who entered treatment in the seventies was down 74 percent 12 years after they entered treatment.[55]Treatment of IV drug users reduced the rate of positive HIV serology.

Chaiken's study found that therapeutic communities in prison are effective.

Petersilia and Turner found that intensive probation does not add to the effectiveness of substance abuse treatment.[56]Finally, Wheeler and Rudolph found that drug testing and treatment is not necessary for success on probation if the probationer has other positive attributes, such as age, risk, and few prior arrests.[57]

Outcomes for Offenders

Previous behavior, including criminal involvement before treatment, may have predictive value. Criminal history may be negatively related to treatment success, according to Anglin and Hser. At the same time other studies have found that offenders tend to remain in treatment longer, and longer periods of treatment are associated with positive outcomes.

The effect of referral to and monitoring of treatment activities by TASC (Treatment Alternatives to Street Crime Projects) has been of particular interest to many evaluators of offender response to treatment.[58]Studies often divide criminal justice clients into those referred through TASC and those not referred through TASC.

The TOPS (1978-1981) survey found that criminal justice clients were more likely to be male, young, have no prior drug abuse treatment episodes, less serious drug abuse patterns (no heroin), and more criminal activity.[59]Within the group from the

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[53] Hubbard, et.al., Op.cit.

[54] Sells and Simpson, Op.cit.

[55] Jim Rua, Treatment Works: The Tragic Cost of Undervaluing Treatment in the "Drug War", National Association of State Alcohol and Drug Abuse Directors, March 1990.

[56] Joan Petersilia and Susan Turner, Intensive Supervision for High-Risk Probationers: Findings from Three California Experiments, National Institute of Justice and the Bureau of Justice Assistance, 1990. R-3936-NIJ/BJA

[57] Gerald R. Wheeler and Amy S. Rudolph, "Drug Testing and Recidivism of Houston Felony Probationers", APPA Perspectives, 14(4), 1990.

[58] James A. Inciardi and Duane C. McBride, Treatment Alternative to Street Crime (TASC): History, Experiences and Issues, National Institute of Drug Abuse, 1991.

[59] Hubbard, et.al., Op.cit.

criminal justice system, TASC clients were more likely to have a high school education, to have fewer arrests, and to have been referred while in pretrial status.

The criminal justice client, particularly the TASC client, stayed in both inpatient and outpatient treatment longer: 45 days longer for TASC clients and 17 for non-TASC criminal justice clients.

Predatory crimes (non-drug related crimes) were down by roughly one-half for participants in all treatment modalities. Criminal justice clients, both TASC and non-TASC clients, were significantly less likely to have a posttreatment arrest if they had been an outpatient client.

Data collected under other auspices suggest that TASC clients remain in treatment longer. As a result, they have better post-treatment success.[60]

Referral through the criminal justice system appears to increase the likelihood of staying in therapeutic community treatment during the first month. It also increases the likelihood of staying in other inpatient treatment programs.

Anglin found that legal coercion probably does not adversely affect the outcomes for treatment. However, it may not significantly improve those outcomes except as it increases the duration of treatment.

Outcomes for Civil Commitment

Civil commitment programs have been used most often to treat the narcotics user who has been arrested. The common practice is to include a period of incarceration at a rehabilitation facility followed by after-care on intensive parole supervision, including frequent urinalysis. Both the federal system and the State of California have assessed the effect of using civil commitment procedures to coerce addicts into treatment.[61] According to these studies, the programs have produced significant decreases in drug use in all groups except chronic addicts. Both studies found the addition of methadone maintenance further reduced drug use.[62]

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[60] Carl G. Leukefeld, "Opportunities for Strengthening Community Corrections with Coerced Drug Abuse Treatment", APPA Perspectives, 14(4), 1990.

[61] See Anglin, Op.cit. for a description of the California civil commitment practice, and H.L.Kitchener and H.E. H. McGlothlin and M.D. Anglin, eds. Haworth, New York, 1990 for Kitchener and Teitelbaum, 1990 for a description of the federal program.Teitelbaum, "A review of research on implementation of NARA Title II in the Federal Bureau of Prisons", The Compulsory Treatment of Opiate Dependence, W.H. McGlothlin and M.D. Anglin, eds. Haworth, New York, 1990 for Kitchener and Teitelbaum, 1990 for a description of the federal program.

[62] Ibid.

OUTCOMES FOR PROTOTYPICAL DRUG/ALCOHOL TREATMENT MODALITIES

Ninety percent of drug abuse treatment occurs in detox, methadone maintenance, therapeutic communities (if that modality is broadened to include newer modifications), and drug-free outpatient treatment.[63] Most alcohol treatment occurs in the community. Outcomes can be described for prototypical modalities.

Anglin found that drug treatment programs are more effective when the duration of treatment is 90 days or more, excluding detox. This, however, may be an effect of who remains in treatment. If poor prospects leave and the good prospects stay, then those who remain longer will do better.[64]

Detoxification

Detoxification programs use licit drugs for the short term to manage withdrawal. For example, the programs focusing on dependence on narcotics use methadone to manage a staged withdrawal over a period of 21 days or more.[65] Gerstein and Lewin found that detoxification can usually be done safely in residential, partial day care, or ambulatory settings rather than in a hospital. Detoxification is most effective when it is the gateway to treatment, but is seldom effective as a stand alone treatment.

Methadone Maintenance

These programs are designed for users of heroin or other morphine-like drugs. Most clients have a history of addiction and previous failed treatment. According to Anglin, they cannot be expected to function without "chemotherapeutic support." Typically in an outpatient setting, the programs impose strict requirements for testing, counseling, and monitored dispensing of medication.

The most effective methadone maintenance may require higher dosages and longer term participation than is the current regime. The majority of programs still operate on reduced dosages and gradual withdrawal from methadone. Anglin, Gerstein and Lewin, and Hubbard all found that practice has increased with funding limitations.

As with other drug treatment programs, longer treatment periods appear to be more effective.[66] Take-home policies which permit more stable clients to reduce their visits to the clinic may improve retention or program duration and thus, outcomes.

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[63] Anglin and Hser, Op.cit.

[64] Anglin and Hser, Op.cit.

[65] Anglin, Op.cit.

[66] Ibid.

Quality of care is positively related to outcomes. This includes more consistent services (Hubbard), flexibility (Anglin), and minimal staff turnover (Gerstein and Lewin).

There is no complete agreement about the importance of frequent urine testing. Some studies suggest that urinalysis has no impact.[67] Others suggest that testing improves treatment outcomes if dirty urines result in sanctions.[68] If a methadone maintenance client is arrested, s/he should be kept on methadone during detention.[69]

Long Term Residential Drug Treatment

Treatment in a therapeutic community, often called a TC, is what is generally meant by residential drug treatment. The residents of traditional therapeutic communities were largely heroin users, but now cocaine users predominate in many TCs.[70] These programs are intense, of long duration, with phased return to independent living. Traditional therapeutic communities operate with strict prohibitions.

The traditional programs are expected to change values and life style. The optimal stay in a traditional program is at least 15 months, according to Anglin. Gerstein and Lewin found the minimum stay necessary to achieve positive outcomes is 90 days.

Successful programs provide close supervision of residents. There is drug testing and expulsion for non-compliance with prohibitions. These programs have high rates of attrition, only 15 to 25 percent finish, but those who do finish are much less likely to use drugs or commit crimes than they were previously. They are also less likely than similar persons who did not receive treatment in a therapeutic community. Variations have evolved. The modified therapeutic community programs have more limited goals, including that clients remain drug free, and gain practical aids to functioning in society.

Short Term Residential Drug/Alcohol Treatment (Non-Therapeutic Community)

Another variation on the therapeutic community is a much shorter residential program with little intent to do more than assist the resident in breaking away from drug use and to connect him or her to other assistance in the larger community. This type of program should not be considered a therapeutic community program. Instead, it may be called a residential chemical dependency program, or a "28 day program".

These 28 day programs were designed for people with alcohol problems and have been extended to drug abusers. The short term programs are often in a hospital

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[67] Hubbard, et.al. Op.cit.

[68] Anglin, Op.cit.

[69] Ibid.

[70] Gerstein and Lewin, Op.cit.

setting although that level of care is not necessary for their operation. They generally run three to five weeks.

This treatment may be followed by as much as two years of self-help or weekly therapy groups, often based on 12 steps of Alcoholics Anonymous. Unlike therapeutic communities, short-term residential programs do not emphasize resocialization.[71]

Gerstein and Lewin contend that these programs are not effective with people whose primary problem is with drugs. However, cocaine abusers report decreased use, down 45 percent after one year. Alcohol abusers' use is reported to decrease 75 percent after one year.[72]

Treatment in Prisons

Estimates of need for prison-based treatment vary. The National Academy of Science suggests that about 30 percent need treatment and 15 percent receive it.

Perhaps two-thirds of all prison treatment programs are equivalent to outpatient nonmethadone programs, self-help groups or classroom drug education. This is the case with Washington prison-based treatment. The other third, including those described by Chaiken, are therapeutic community programs in which clients are separated from the general population.

The report from the National Academy of Science singled out the success of prison-based therapeutic communities with strong links to the community.[73]Their report notes the failure of other correctional treatments to reduce recidivism, and the success of these programs in reducing rearrest by 10 to 20 percent. Chaiken found that prison based programs reduced recidivism significantly if they were modeled after the therapeutic community's residential treatment.

Kitchener and Teitelbaum's evaluation of the NARA program within the Federal Bureau of Prisons showed that prison programs could be effective if they used initial screening, mandatory participation in prison programs, supervised after-care, intensive parole surveillance and assistance in obtaining employment, and if clients could be motivated to succeed either through sentencing sanctions or therapy.[74]

Outpatient Treatment

Drug-free care means that no drugs are part of the treatment (as in methadone) or that a client goes off all medications, including psychotropics, during treatment.

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[71] Hubbard, et.al., Op.cit.

[72] Anglin, Op.cit.

[73] Gerstein and Lewin, Op.cit.

[74] Kitchener and Teitelbaum, Op.cit.

Some outpatient clients may have just completed a course of residential treatment, but the majority enter outpatient treatment directly. Thus, the outpatient client is usually less impaired and has a less serious criminal history.

The first outpatient programs were designed to serve non-opiate users. They were extensions of the crisis clinics and intended to provide short term interventions. As short term interventions were found to be insufficient, programs developed more extensive outpatient services.[75]

The result is, at minimum, two types of outpatient treatment. One is a clinical service, staffed by professionals who may or may not have a history of chemical dependency. These programs can be quite intensive, including structured day treatment, or less intrusive, offering a few hours of group therapy per week. The second type of outpatient treatment is typically provided by ex-addict staff and based on the 12 step program of AA. It is important to distinguish between the two, but not all assessments specify treatment in sufficient detail.

The TOPS survey included outcome data for the more clinical outpatient treatment and not for the less structured programs. Regardless of their design, outpatient drug programs have higher drop out rates than either residential or methadone maintenance programs, and they are less successful in reducing drug use or criminal behavior.[76]These results might well be modified if the effects of specific outpatient treatments were assessed.

The studies assessed by the National Academy of Science were for drug abusers. These programs were drug-free except for prescribed psychoactive medications. Rapid attrition was common to these programs. Gerstein and Lewin concluded that, despite heterogeneity in treatment process, philosophy and staffing, outcomes were better for the participants than for non-participants. They noted that participants in outpatient treatment did better than those who had detoxification services only.

Attrition is also a factor when the client is an alcoholic. Fifty to 75 percent of the outpatients in alcoholism treatment drop out within four sessions. Five to ten sessions are required for effectiveness with alcoholics. Longer treatment periods increase positive results for alcoholics.[77]Again, duration of treatment is an important attribute of a successful program.[78]

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[75] Hubbard, et.al., Op.cit.

[76] Anglin, Op.cit.

[77] Francis S. Gilbert, "The Effect of Type of Aftercare Follow-Up on Treatment Outcome among Alcoholics", Journal of Studies on Alcohol, 49:2, 1988.

[78] Gerstein and Lewin, Op.cit.

SUMMARY

There is considerable evidence that drug treatments, particularly methadone maintenance and therapeutic communities, are effective. The other forms of drug treatment appear to have positive effects but that impact is less supported by current studies. The work on effectiveness of alcohol treatment is less definitive. There have been fewer studies for each specific modality. What has been done suggests that some but not all forms of treatment are effective. Treatment of offenders while in prison does work, if that treatment follows the therapeutic community approach.

An assessment of prison treatment in Washington showed high completion rates and positive impact on subsequent behavior. Assessments of completion rates for both ADATSA and all publicly funded clients show varying rates of completion depending upon the modality. Clients are more likely to finish an inpatient treatment than an outpatient treatment.

CRIMINAL JUSTICE DEMAND FOR TREATMENT SERVICES

INTRODUCTION

Criminal justice professionals, particularly those involved in sentence recommendations and decisions, have long said that many more offenders require substance abuse treatment than the treatment system can handle. Because there is ongoing interest in some quarters to expand the use of substance abuse treatment for some offenders as an alternate or supplement to criminal sanctions, members of the Advisory Board for the 1991 Capacity Study: Offender Placements in Washington State successfully argued for an assessment of substance abuse treatment capacity and demand in Washington State.

This section of the report deals with demand for substance abuse treatment that is attributable to offenders.

An estimate of treatment demand attributable to offenders has never been attempted in Washington State. Developing a definitive estimate of this demand is beyond the scope of this study and would require considerably more time and resources than were available. Consequently, a variety of methods have been used to develop an approximation that can be used as a starting point for further analysis and policy development.

Whatever the actual demand may be, it is very large. First of all, the number of offenders under some form of criminal justice control in Washington State is substantial. The recently completed 1991 Capacity Study reports the results of a survey of local county and city jails; lower court probation services; state operated prisons, pre-release and work release centers; state community supervision programs; electronic home detention programs; and out-of-custody work crews.[79] That survey concluded that more than 90,000 offenders were under some form of supervision in the criminal justice system on July 1, 1991. Of these, more than 80 percent had been convicted of a misdemeanor or felony. The remainder were persons charged with crimes (mostly felonies), but not yet adjudicated.

Many of these offenders have treatment orders (not all of which are *substance abuse* treatment orders) as a condition of their sentence. For example, 10 percent of the misdemeanor deferred prosecution cases, 85 percent of the misdemeanor probation cases and 17 percent of the felons on community supervision had been ordered to treatment by the court of jurisdiction. A significant portion of these orders were for substance abuse treatment.

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[79] Christopher Murray and Merlyn Bell, 1991 Capacity Study: Offender Placements in Washington State, Washington Department of Corrections, February 1992.

In this section we first examine the incidence of substance abuse in the general population and the offender population. We then describe the laws and practices that cause offenders to be referred for treatment. Finally, we explore two methods of estimating the demand for substance abuse treatment services attributable to offenders.

INCIDENCE OF SUBSTANCE ABUSE

While the use of alcohol is pervasive in our society, illicit drugs are used regularly by a very small percentage of the population. Many of those using illicit drugs have criminal histories. For example, a significant number of people arrested are arrested for drug or alcohol related offenses. Other offenders either admit being under the influence of drugs while committing an offense, or test positive for drugs when first detained. The prevalence of drug and alcohol abuse among offender populations is known to be significantly higher than among the non-offender population.

In estimating the demand for substance abuse treatment attributable to offenders, our first step is to examine the prevalence of alcohol and drug use and abuse. Because there is little specific data pertaining to Washington State, national studies provide most of the data.

Use versus Abuse

While related, the need for substance abuse treatment should not be confused with the prevalence of drug use. Far more people use drugs than abuse drugs. Nationally, it is estimated that the number of people using illicit drugs is 4.5 times higher than the number abusing or dependent on illicit drugs.

According to the National Institute on Drug Abuse 1988 Household Survey, 11 percent of persons 12 years and older have tried cocaine; 1.5 percent have used it within the last 30 days.[80] Thirty-three percent of persons 12 years and older have used marijuana; 6 percent have used it within the last 30 days. Eighty-five percent have used alcohol, 53.4 percent within the last 30 days. Nearly two-thirds of the younger adult population (18 to 34 years old) and half of the older adult population (over 34 years old) have used alcohol within the last 30 days.[81]

From a self-reported survey of households, the homeless and those in the criminal justice system, 5.5 million people in the U.S. were identified as dependent

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[80] Sourcebook of Criminal Justice Statistics 1990, U.S. Department of Justice, Table 3.86: 1988 survey data.

[81] Ibid., Table 3.86.

on or abusing drugs.[82] Of this group more than 1 million in the criminal justice system were described as clearly in need of treatment for drug dependencies.

Gerstein and Harwood, writing for the National Academy of Science Institute of Medicine, estimate that 1.5 million in the household population clearly need treatment for drug dependencies. In the same study, they estimate that one-third of all prison and jail inmates and one-fourth of all parolees and probationers need treatment.[83]

Substance Abuse in the Offender Population

In the United State there were more than 9.5 million arrests of adults for non-traffic offenses in 1989. Just over a fourth of these arrests, or nearly 3 million, were for alcohol-related offenses. Of the alcohol-related arrests, 45 percent were for driving under the influence. The others were for liquor law violations, drunkenness, disorderly conduct, and vagrancy. Almost a million more arrests (10 percent) were for drug abuse violations.[84] The number of offenders who are arrested for drug or alcohol offenses is just one part of the substance abuse problem. Many offenders with substance abuse problems are not arrested for a drug or alcohol offense.

A number of national studies illustrate this point.

As part of a national study in 1983 and 1989, jail inmates were asked to report illicit drug use. Three-fourths of all jail inmates said that they had used drugs at least once. Twenty-nine percent admitted to being under the influence of alcohol at the time of the offense. Nearly half of the convicted inmates admitted drug use within the month prior to the offense. Alcohol involvement was more often present in violent crimes and public-order offenses. Drug involvement was more common when the offense was drug related. When jail inmates were asked if they had committed their offense to obtain money for drugs, thirteen percent said yes.[85]

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[82] Gerstein and Lewin, Op.cit.

[83] Dean R. Gerstein and Henrick J. Harwood, eds. Treating Drug Problems, National Academy Press, Washington, DC 1990.

[84] Ibid, Table 4.6.

[85] Caroline Wolf Harlow, Drugs and Jail Inmates, 1989, Bureau of Justice Statistics, US Department of Justice, August 1991.

The Drug Use Forecasting Project (DUF)[86] is another study that helps illustrate the problem. Since 1987, jails in 24 cities have periodically tested a sample of arrestees for drug use. (No Washington cities participate in the Drug Use Forecasting project.) A representative group of new detainees were asked to submit to the test, the results of which remain anonymous. About 80 percent of those approached agreed to the test, and two-thirds tested positive for some drug. The most common drug used was cocaine. Marijuana use had been high, but has declined since testing began.

In the same study, jail inmates were asked about participation in substance abuse treatment. A third of those who had ever used drugs said they had been in treatment; 39 percent of those who had ever used a major drug said they had been in treatment. Slightly more than 5 percent were in treatment when arrested.[87]

Other studies report similar findings. The US Accounting Office reported in a September 1991 report that as much as 75 percent of all prison inmates have substance abuse problems.[88] Marcia Chaiken states that, in 1979, the number of inmates nationally who had used heroin, illicit methadone, cocaine, LSD or PCP once a week or more for at least a month totaled about 100,000.[89] By 1986, that number had grown to 140,000. In the same report another 250,000 inmates said they had regularly used these drugs.

Prevalence Rates for Substance Abuse

A major National Institute of Mental Health study of prevalence of mental disorders, including alcohol and drug abuse, reported lifetime prevalence rates for substance, alcohol and drug abuse disorders in the community and for the detained offender population. Lifetime prevalence rates count individuals who, at some time during their lives, meet the DSM III diagnostic criteria for substance abuse. The detained offender population includes persons in jail, in prison, and in residential alcohol/drug treatment facilities. The treatment facilities are categorized with jails

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[86] DUF, Drug Use Forecasting, National Institute of Justice, US Department of Justice, June 1991. Drug use by offense data have been compiled from these data. More of the persons arrested for drug sales/possession, burglary, larceny, robbery, prostitution, and probation violations test positive upon arrest for drug use. See re-analysis reported in Sourcebook 1990, Op.cit., Table 4.36.

[87] Sourcebook 1990, Table 6.45.

[88] United States Accounting Office, Drug Treatment: State Prisons Face Challenges in Providing Services, September 1991.

[89] Marcia R. Chaiken, In-Prison Programs for Drug-Involved Offenders, National Institute of Justice, US Department of Justice, July 1989.

TABLE 2
LIFETIME PREVALENCE OF ALCOHOL OR DRUG DISORDERS[91]

DISORDER	PRISON/JAIL/RESIDENTIAL SUBSTANCE ABUSE TREATMENT POPULATION	TOTAL POPULATION
Substance abuse (any)	72.0%	16.7%
Alcohol	56.2%	13.5%
Drug	53.7%	6.1%

Lifetime prevalence rates cannot be used to forecast current treatment need. The same study also discusses active (one year) rates for drug abuse/dependence and alcohol abuse/dependence. This is a better indicator of treatment need.

TABLE 3
ACTIVE (ONE YEAR) PREVALENCE OF ALCOHOL OR DRUG DISORDERS[92]

DISORDER	PRISON POPULATION			TOTAL POPULATION		
	MEN	WOMEN	TOTAL	MEN	WOMEN	TOTAL
Drug Abuse	19.45	44.94		7.58	4.79	
Alcohol Abuse			26.4			5.9

Based upon these rates, it can be concluded that the active prevalence rate for alcohol abuse in prison populations is about 4.5 times that of the general population. Assuming that the offender population is about 90 percent male, the active prevalence rate for drug abuse in the prison population is about 3.6 times that of the general population.

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[91] Darrel A. Regier, Mary E. Farmer, Donald S. Rae, Ben Z. Locke, Samuel J. Keith, Lewis L. Judd, Frederick K. Goodwin Comorbidity of mental disorders with alcohol and other drug abuse: results from the epidemiologic catchment area (ECA) study Journal of the American Medical Association November 21, 1990, vol 264, no. 19, 2511-2518.

[92] Reiger, Farmer, Rae, et al

The national numbers clearly show that offender populations generate a significant demand for substance abuse treatment services.

Substance Abuse by Offenders in Washington State

In Washington, 177,735 adults were arrested in 1989. Just over a fourth were arrested for alcohol-related offenses, 68 percent of those for driving while intoxicated. Five percent were arrested for drug abuse violations.[93]

In 1989 there were an estimated 41,743 filings and 16,577 convictions for drinking while intoxicated. An estimated 6,968 of the arrests and 3,172 of the convictions were for repeat DWI offenses.[94] In FY 1991 there were 5,159 sentences for Violation of the Uniform Controlled Substances Act.[95]

The Washington State Department of Corrections records show that 82 percent of the offenders sentenced to their institutions are or have been chemically (either alcohol or drug) dependent.[96]

TREATMENT CONDITIONS FOR SENTENCED OFFENDERS

In Washington, an offender may be required to have treatment as a condition of a misdemeanor or felony sentence or of a deferred prosecution of a misdemeanor or felony offense.

Misdemeanor Sentences: Imposition of Conditions

Under the statutory provisions for misdemeanor sentencing there are two routes into treatment: either through a deferral of prosecution on the condition that the offender participate in a treatment program; or a deferred or suspended jail sentence (probation) which includes an order that the offender take part in a treatment program.

Washington statutes specify the general provisions of misdemeanor deferred prosecutions or sentences; they cannot exceed one year in jail or two years of probation.

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[93] Crime in Washington State, Washington Association of Sheriffs and Police Chiefs, 1990.

[94] Brent Baxter and Jeanne Kleyn, Washington State's Second Offender Laws for Driving While Intoxicated: Results of Five Years of Evaluation, Alcohol and Drug Abuse Institute, University of Washington, Seattle, May 1991.

[95] Sentencing Guidelines Commission, A Decade of Sentencing Reform: Washington and Its Guidelines, January 1992.

[96] Department of Corrections, Substance Abuse Treatment Program Evaluation, November 1986.

Statutory requirements for treatment are quite explicit for driving while intoxicated. The first offense carries a penalty of one day in jail, the second offense a penalty of seven days. These sentences may also be suspended or deferred if imposition of the sentence would pose a "risk to the defendant's physical or mental well-being". Judges must put these reasons in writing. Alcohol information school is required, as is evaluation and, when deemed appropriate, treatment.

Every person convicted of a violation of RCW 46.61.502 or 46.61.504, driving under the influence:

> *"...shall, in addition, be required to complete a course in an alcohol information school approved by the department of social and health services or more intensive treatment in a program approved by the department of social and health services, as determined by the court. A diagnostic evaluation and treatment recommendation shall be prepared under the direction of the court by an alcoholism agency approved by the department of social and health services or a qualified probation department approved by the department of social and health services.... Based on the diagnostic evaluation, the court shall determine whether the convicted person shall be required to complete a course in an alcohol information school approved by the department of social and health services or more intensive treatment in a program approved by the department of social and health services.... The courts shall periodically review the costs of alcohol information schools and treatment programs within their jurisdictions."* (RCW 46.61.515)

On a second or subsequent conviction, the person shall:

> *"...be required to complete a diagnostic evaluation by an alcoholism agency approved by the department of social and health services or a qualified probation department approved by the department of social and health services.... If the person is found to have an alcohol or drug problem requiring treatment, the person shall complete treatment at an approved alcoholism treatment facility or approved drug treatment center."* (RCW 46.61.515)

Some individual courts have adopted guidelines for misdemeanor deferred prosecution and sentencing. Seattle Municipal Court and Thurston County District Court are two examples. Their guidelines suggest what may be commonly accepted practices for ordering treatment. In Seattle Municipal Court, pretrial diversion is available for persons with no criminal record, other than criminal traffic, who are charged with a series of specific offenses, not including domestic violence. A diversion case in Seattle is for 90 days and may include alcohol information school. In Thurston County District Court, the guidelines specify an alcohol referral for all DWI offenses or for driving while one's license is suspended or revoked (if the suspension was the result of a failure to comply with alcohol treatment or was accompanied by a DWI or major traffic offense.) Possession of marijuana has drug referral as a condition independent of other factors. When alcohol or drug related activity is present with any other offense, initiation of the alcohol or drug treatment process is recommended under the Thurston County guidelines.

Felony Sentences: Imposition of Conditions

Under the terms of the Sentencing Reform Act (SRA), sentencing occurs within guidelines designed to ensure that offenders with similar crimes and similar criminal histories receive equivalent sentences. All felonies committed on or after July 1, 1984 fall under the SRA. Those felons sentenced prior to that time remain under the prior system.

The SRA limits the use of treatment orders. Only the First-Time Non-Violent Offender Waiver or the Special Sex Offender Sentencing Alternative (SSOSA) permit treatment conditions. However, community placement of persons released from prison may include treatment requirements.

Under the First-Time Offender Waiver, the court can require up to two years of community supervision which may include "outpatient treatment for up to two years or inpatient treatment not to exceed the standard range of confinement for that offense."[97] Eligibility for First-Time Offender Waivers is restricted to persons who have not been convicted of a violent offense; of manufacture, delivery, or possession with the intent to manufacture or deliver a Schedule I or II drug; of selling for profit any controlled substance or counterfeit substance; of a sex offense; of a previous felony; have participated in a deferred prosecution for a felony; have a juvenile adjudication for a felony offense after age 15 or have any adjudication for a sex offense as a juvenile.

There were 2,472 First-Time Offender Waivers exercised in 1990.[98] Less than 50 percent had treatment orders of any kind; even fewer had orders for alcohol or substance abuse treatment. Under the Special Sex Offender Sentencing Alternative, the court can require outpatient or inpatient treatment as part of a suspended sentence.[99] Although alcohol or drug treatment may be a part of a treatment program, they are secondary to the sex offender behavior and probably do not generate any significant demand for substance abuse treatment services. In 1990, 402 persons were sentenced under this provision.

All sentences of one year or less may include up to one year of community supervision. Community supervision, other than that for First-time Offender Waivers or Special Sex Offender Sentencing Alternatives, can include crime-related prohibitions but not rehabilitative conditions. Thus an offender sentenced to one year of community supervision may be prohibited the use of alcohol or drugs, if the court decides their use was a factor in the crime. That prohibition may include regular urinalysis or breathalyzer

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[97] Sentencing Guidelines Commission, Implementation Manual 1991, p. I-20.

[98] David Fallen, A Statistical Summary of Adult Felony Sentencing: Fiscal Year 1990, Sentencing Guidelines Commission, State of Washington, February 1991.

[99] Ibid., pp. I-21 - I-24.

testing, but the court may not order treatment except as part of an exceptional sentence.[100]

Community placement (post-prison supervision) is limited to certain offender groups: sex offenders, drug offenders, certain non-property offenders. Community placement offenders may be court ordered to participate in "crime-related treatment or counseling services."[101] Some portion of this population would represent demand for substance abuse treatment services.

Sentences to total confinement may be served in a "facility or institution operated or utilized under contract by the state or any other unit of government for twenty-four hours a day, or pursuant to RCW 72.64.050 and 72.64.060."[102] This provision permits in-patient treatment under the proper conditions. Some offenders could serve time in an alcohol or drug in-patient facility as a day for day substitute for jail time. There are infrequent orders for residential treatment accompanying a jail sentence.

During the 1991 Legislative Session, the Sentencing Guidelines Commission proposed a new treatment option for drug offenders which would have required treatment, beginning in prison and continuing in the community, for some offenders. The expectation was that just over 1,000 cases would have been eligible. But the legislation did not pass.

During the 1992 Legislative Session, the Commission proposed two additional bills, both with treatment options. The first bill was for nonviolent offenders with presumptive jail sentences; it would make possible sentencing offenders with substance abuse problems to out-patient, inpatient or residential treatment. The second bill was for drug offenders with presumptive prison sentences of one to five years, and would integrate their prison and community treatment. About 1,000 offenders would require community substance abuse treatment under the second bill. Neither bill passed.

CALCULATION OF DEMAND

Offenders Under Local Criminal Justice Control

Nearly 63,000 misdemeanor arrests for drug or alcohol offenses were reported in Washington in 1989. Very few defendants are found not guilty when charges are filed; less than one percent of the DWI charges filed in 1989 resulted in a disposition of not guilty. The misdemeanor sentencing laws permit the attachment of treatment conditions to any sentence.

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[100] Ibid., pp. I-27 and II-27.

[101] Ibid., p. I-27.

[102] Ibid., p. II-10.

Data from 1991 Capacity Study identified the number of misdemeanants in various offender placements through means of a survey. Of 28 jurisdictions with probation agencies in July, 1991[103], 19 participated in the survey. Correcting for under reporting, the July 1, 1991, caseloads for all 28 agencies were estimated at 7,300 on deferred prosecution and 32,422 on probation.

If all or most of these offenders were required to have alcohol or drug abuse treatment, it would have a considerable impact on the treatment system. Not all do, but the total number is still large. According to the 1991 Capacity Study, about 10 percent of the deferred prosecution cases reported by agencies had treatment conditions and nearly 85 percent of the probation cases had treatment orders.

If 10 percent of the estimated 7,300 deferred prosecution cases have treatment orders, that represents 730 cases. If 85 percent of the estimated 32,422 probation cases have treatment orders, that adds another 27,559 cases with orders. Together the two groups could have as many as 28,289 treatment orders.

The number of misdemeanants on community supervision and the estimated number with treatment orders are shown in the following table.

TABLE 4
ESTIMATED MISDEMEANANTS WITH TREATMENT ORDERS[104]
AS OF JULY 1, 1991

OFFENSE	DEFERRED PROSECUTION	PROBATION	TOTAL CASELOAD
Felony	595	0	595
Misdemeanor	2,911	20,018	22,929
DWI	2,968	8,561	11,529
Traffic	514	3,709	4,223
Other	312	134	446
Total	7,300	32,422	39,722
Estimated % with Treatment Orders	10%	85%	71%
Estimated Number with Treatment Orders	730	27,559	28,289

[103] Pacific and Klickitat probation agencies were closed, and Kittitas opened during the period of the study.

[104] The probation agencies in Benton, Clallam, Jefferson, Kittitas (newly opened), Snohomish: Cascade and South District, Olympia, Walla Walla, and Yakima Counties did not respond to the Offender Placement Survey.

In addition to persons supervised by lower court probation agencies, others fall under the jurisdiction of a lower court not affiliated with a probation agency. These courts supervise some deferred prosecution cases and some suspended sentence cases using court staff. In a survey of the latter agencies, nine out of ten reported deferred prosecution for a total of more than 2,000 misdemeanor and traffic offenders; many of these were probably DWI offenders. Two out of three agencies reported supervision of another 3,500 sentenced misdemeanor and traffic offenders.[105] These 5,500 cases would enlarge the pool of lesser offenders with treatment conditions. However, many of this group do not have treatment orders. For one thing, there is no staff whose sole job it is to supervise offenders. If they had the same percentage of treatment orders as in the other caseloads of the probation agencies, the demand for treatment from sentenced misdemeanants would be 4,675 cases.

In addition to those sentenced misdemeanants on local supervision, another 6,511 persons were in jail or special detention on July 1, 1991, and 563 were in partial local confinement. There is no specific information regarding the percentage of these offenders who require substance abuse treatment or have orders for treatment. If they had the same rate of chemical dependency as the prison population (82%), then 5,801 would need treatment.

TABLE 5
ESTIMATED NUMBER OF TREATMENT ORDERS for
OFFENDERS UNDER LOCAL CRIMINAL JUSTICE CONTROL

OFFENDER PLACEMENT	ESTIMATED NUMBER WITH TREATMENT ORDERS
Local Probation Agency	28,289
Court Supervised Probation	4,675
Local Confinement	5,801
Total	38,765

It is important to emphasize that not all of these treatment orders are for substance abuse treatment. However, given the prevalence of alcohol and drug problems in this population and the association between those problems and treatment orders in both statute and sentencing guidelines, one could assume that a sizeable, albeit unknown, percentage of those orders are for alcohol or drug treatment of some form.

[105] Murray and Bell, Op.cit.

Offenders under State Criminal Justice Control

The Washington State Department of Corrections (DOC) is responsible for offenders sentenced to confinement terms exceeding one year and for supervision of a variety of offenders who spend some or all of their time in the community.

DOC data indicate that as many as 82 percent of the imprisoned population has a chemical dependency problem. Heroin and cocaine are the drugs most commonly used by the serious offender population.[106] Data collected by the Washington Department of Corrections does not include primary drug by rate of use. However, Oregon may be an appropriate surrogate. About half of the persons held by the Oregon Department of Corrections reported some use of cocaine; nearly half of those reporting used regularly. Fewer (24 percent) had used heroin and fewer had used recently, but a larger percentage used heavily. Twenty percent of the population said it was considerably or extremely important to them to get treatment for drug dependency; 20 percent said the same about alcohol dependency.[107]

On July 1, 1991, 8,439 offenders were in prison and 436 were under partial confinement in state work release facilities. If 82 percent of these inmates have a significant chemical dependency problem, then 7,278 state incarcerated offenders could require treatment.

In addition to the imprisoned population, the Department of Corrections is responsible for all sentenced felons with treatment orders or recommendations for treatment.

The need for treatment may be identified from the Judgment and Sentence Form in several ways. The judge may recommend that an offender be evaluated to see if a need for treatment exists; or the judge may order that an offender be sent to treatment, when and if a place is available. The language used varies from judge to judge, leaving the community corrections officer to implement the judge's recommendation or order.

These recommendations are for all kinds of treatment, some of which are unrelated to substance abuse. For example, anger management is a common treatment requirement. Data are not available to distinguish substance abuse treatment requirements from other forms of treatment. However, if the percentage of offenders in the community who needed substance abuse treatment is the same as the percentage institutionalized with a history of substance abuse problems (82 percent), then an estimated 11,950 persons on community supervision have a chemical dependency problem. Of that group, perhaps 4,435 offenders have a recommendation or an order for substance abuse treatment in their judgment and sentence. See Table 6.

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[106] M. Douglas Anglin, "Ensuring Success in Interventions with Drug-Abusing Offenders", RAND conference, Santa Monica, CA, April 1991.

[107] Dr. Ron Jemelka, Unpublished data, 1992.

TABLE 6
STATE COMMUNITY CORRECTIONS CASELOAD
WITH ESTIMATE OF SUBSTANCE ABUSE NEEDS
ON JULY 1, 1991[108]

SUPERVISION LEVEL[109]	TOTAL CASELOAD	EST NUMBER WITH CHEMICAL DEPENDENCY PROBLEM[110]	EST NUMBER RECOMMENDED FOR SUBSTANCE ABUSE TX[111]
Level 1: Community Custody	490	402	161
Level 2: Post-Release Supervision	580	476	114
Level 3: SRA Offenders with Crime-Related Prohibitions	8,150	6,683	3,609
Level 4: SRA Offenders without Crime-Related Prohibitions	2,577	2,113	528
Level D: Indeterminate Sentence Offenders	2,775	2,276	23[112]
TOTAL	14,572	11,950	4,435

Together, there may be as many as 11,713 offenders confined in state facilities or under state supervision who may require substance abuse treatment. (7,278 in confinement + 4435 under state supervision = 11,713)

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[108] This table does not include those persons who are still being monitored, primarily to determine if they are meeting their financial obligations, and who are inactive. Neither group can be brought into treatment as part of their current supervision.

[109] This level system was in place when the census data for 1991 Capacity Study was collected. Since then, the Department of Corrections Division of Community Corrections has changed their supervision level system.

[110] Estimate based on an 82 percent rate for chemical dependency.

[111] Estimate based on numbers with treatment recommendations as reported in the 1991 Capacity Study.

[112] The offender based tracking system is not programmed to track the number of pre-SRA cases with treatment requirements. This reflects only those with an underlying SRA requirement for treatment. Thus, it is an underestimate of the percentage of cases in this category.

Summary of all Offenders under Criminal Justice Control

Table 7 summarizes this first calculation of demand, showing the estimated number of offenders who may have need of substance abuse treatment. By this method of estimation over 50,000 offenders may require treatment.

TABLE 7
ESTIMATED NUMBER OF OFFENDERS WITH TREATMENT RECOMMENDATIONS

TYPE OF PLACEMENT	ESTIMATED NUMBER WHO ARE CHEMICALLY DEPENDENT AND HAVE TREATMENT RECOMMENDATIONS
Local Confinement	5,801
Local Supervision	32,964
State Confinement	7,278
State Supervision	4,435
TOTAL	50,478

ALTERNATIVE ESTIMATE OF DEMAND FOR TREATMENT

The NIMH prevalence study cited earlier suggests that the substance abuse rates for offenders can be derived if we know something about those rates for the general population. Substance abuse rates for offenders are much higher than for the general population. The lifetime rates are nine times higher for offender drug disorders than for the general population and four times higher for alcohol disorders. The combined rates for offender substance abuse are 4.3 times that of the general population.

In the next few paragraphs we look first at total demand for treatment and then use the relationship between offender prevalence rates and general prevalence rates to derive an alternate estimate of demand for treatment.

Total Demand for Treatment

Offenders who are court ordered or recommended to receive substance abuse treatment represent only one stream of demand for those services. Others enter treatment not because of an arrest, but for other equally compelling reasons: they have lost a job; their family demands it; their health is failing.

DASA's Needs Assessment Report for 1990 indicates 465,062 possible adult clients in Washington.[113] See Table 5. Note that detoxification and outpatient services

[113] Elizabeth Kohlenberg, Rebecca Yette, and Curtis E. Mack, Needs Assessment Data Project Report, Office of Research and Data Analysis, DSHS, 1992, #11-58.

are estimated at the same level as total services, since the assumption is that these services are needed by all.

TABLE 8
ESTIMATED TOTAL DEMAND (OFFENDERS + GENERAL POPULATION)
FOR SUBSTANCE ABUSE TREATMENT

SERVICE	ESTIMATED DEMAND	RATE per CAPITA[114]
Detoxification	465,062	9.6%
ADATSA Assessment	176,362	3.6%
Residential	176,362	3.6%
Outpatient	465,062	9.6%
Methadone	32,252[115]	0.7%
Total	465,062	9.6%

From the DASA Needs Assessment Report it is not possible to divide the offender client from the non-offender client. However, a sizeable portion of this need is generated by offender clients.

What is known about the proportion of Washington substance abuse clients who are offenders comes from two recently completed studies: one of Alcohol and Drug Addiction Treatment and Support Act (ADATSA) clients[116] and the other of all DASA clients.[117]

From these sources it is known that nearly three-fourths of the ADATSA clients were involved with the criminal justice system at some point in their lives. (Seventy-two percent of those assessed for ADATSA treatment have been arrested or charged with

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[114] The prevalence rates are derived by dividing the total possible clients in each treatment service by the total Washington population.

[115] This number is an estimate of all persons who have ever been opiate dependent, including many for whom methadone would not be an appropriate treatment during FY 1990.

[116] Dario Longhi, The ADATSA Program: Clients, Services and Treatment Outcomes, Washington Department of Social and Health Services, Office of Research and Data Analysis, October 1991.

[117] Kohlenberg, Yette and Mack, Op.cit.

a crime.[118]) Almost half had been charged with driving while intoxicated at least once. Twenty-five percent were on probation or parole when most recently assessed or treated. Twenty percent were assessed as the result of a court order.

Persons receiving residential treatment that was funded (either partially or fully) by DASA were rarely referred by the courts; less than two percent entered residential treatment as the result of a court referral. Somewhat more of the long term drug clients came through the courts, but still only nine percent entered by that route. Most residential services clients came from assessment centers.

A larger proportion of demand for outpatient services can be traced to court referrals. One third of the outpatient treatment clients were referred by the courts, and half of the intensive outpatient clients came from the courts.

Estimated Offender Demand for Treatment Based on Prevalence Rates

The lifetime prevalence rates for substance abuse from the NIMH study (see Table 1a above) suggest that imprisoned populations are 4.3 times as likely to have a substance abuse disorder. Using the Washington prevalence rate for all substance abuse services (9.6 percent) and multiplying that rate by 4.3 to adjust for the higher prevalence of institutionalized populations, then the rate for confined offenders should be 41 percent.

A prevalence rate of 41 percent for confined populations (16,181 on 7/1/91) would mean a demand for treatment for 6,634 prisoners. (See Table 9)

The prevalence rate for the confined population is not appropriate for all persons under community supervision. In the larger prevalence studies such persons have been treated as though they were any other community resident. In Washington that would mean a prevalence rate of 9.6 percent.

However, persons under *state* community supervision are the same as persons in jail and probably have the same rate of substance abuse. If 41 percent of the 36,343 persons on state community supervision and 9.6 percent of the 36,674 on local supervision have a current substance abuse problem, then 18,422 offenders in the community would require treatment.

These groups would total 25,056 offenders needing treatment in any one year. Table 9 summarizes this alternative method of estimating demand.

[118] Longhi, Op.cit.

TABLE 9
ALTERNATIVE ESTIMATED DEMAND FOR SUBSTANCE ABUSE TREATMENT
1991

TYPE OF PLACEMENT	NUMBER OF OFFENDERS BY TYPE OF PLACEMENT[119]	EST NUMBER OF OFFENDERS WITH SUB ABUSE TX NEEDS	PREVALENCE RATE
Local Confinement	7,074	2,900	41.0%
Local Supervision	36,674	3,521	9.6%
State Confinement	9,107	3,734	41.0%
State Supervision	36,343	14,901	41.0%
All Placements	89,198	25,056	28.1%

NEED versus TREATMENT

Need is not equivalent to receipt of treatment. Some people are not amenable to being treated. The DASA data suggest that half of the people referred for treatment and determined eligible, start treatment. If half of the offenders needing treatment were to enter treatment, then (based on our two methods of estimating demand) between 12,500 and 25,000 would enter treatment. In other parts of this report, the lower figure is used.

SUMMARY

Persons using illicit drugs are a relatively small percentage of the general population and a relatively large percentage of the offender population.[120] One can also conclude that much of the demand for treatment for illicit drug abuse comes from offenders or ex-offenders.

It is more difficult to reach the same conclusions regarding the population using alcohol with some regularity. The 3,000,000 arrests nationally for alcohol related offenses, combined with other offenses committed while under the influence of alcohol, account for a relatively small percentage of the total adult population making monthly or more frequent use of alcohol. However, persons with a history of alcohol abuse combined with related offenses may be a large percentage of the clients receiving

[119] See 1991 Capacity Study, Section 4, page 5.

[120] A review of prevalence data and its relationship to drug policies will be available: Eric Wish, "U.S. Drug Policy in the 1990's: Insights from New Data from Arrestees", a unpublished manuscript dated February 22, 1990, to be published in The International Journal of the Addictions.

alcohol treatment, particularly when that treatment is publicly funded, such as with ADATSA.

The 89,198 offenders under correctional control on July 1,1991 were 1.8 percent of the Washington population. Just under 10 percent of state's population is estimated to need substance abuse treatment; that is 465,062 people who need substance abuse treatment in any one year. The demand for treatment by offenders is somewhere between 50,478 (or 10.9 percent) and 25,056 (or 5.4 percent of the total demand). Only half of the offenders who need it may enter treatment. Thus, the real demand for substance treatment generated by those offenders under correctional control on July 1,1991 is likely between 12,500 and 25,000.

CURRENT CAPACITY
OF PUBLICLY FUNDED (STATE) TREATMENT PROGRAMS

INTRODUCTION

In the community there are eight types of publicly funded substance abuse treatment services that provide services to offenders: alcohol/drug assessments, intensive inpatient, recovery house, extended recovery house, long term residential, intensive outpatient, regular outpatient services, and methadone maintenance. The Department of Corrections provides substance abuse treatment programs for offenders in its institutions and in its community residential facilities. In this section of the report we examine the capacity of these programs.

DASA and DOC provided the information cited below. The DASA information is compiled from contracts between DASA and counties, from reports submitted by local providers of treatment services, and from three recent studies on DASA services. The DOC information was compiled from contract documents with treatment providers and from information provided by headquarters staff.

STATE FUNDED TREATMENT MODALITIES

During the 1991-1993 biennium, the Division of Alcohol and Substance Abuse contracted with counties to provide $51,936,289 in community based services. These dollars are exclusive of the monies set aside for county administration and planning for alcohol and substance abuse services. In addition, they include dollars for services beyond the scope of interest of this report. Contract sums relevant to this report included $4,542,080 for assessments (DWI, alcohol/drug and ADATSA); $22,399 for alcohol/drug information school; $1,884,517 for intensive outpatient treatment services; $7,664,492 for outpatient services; $5,432,612 for ADATSA outpatient service; and $1,899,195 for methadone treatment services.

DASA further contracted with residential services providers for $23,017,641 during the biennium. The total is nearly $75 million.

Chemical Dependency Assessment Services

Chemical dependency assessment determines whether or not the client is alcohol or drug addicted and whether or not the client is incapacitated as a result of that addiction. If indicated, a treatment plan is prepared in consultation with the client.

Less than 1 percent of the state's budget (0.5) for substance abuse services is identified for DWI assessment; 6.7 percent is devoted to ADATSA assessments. Less than 2 percent (1.6) is set aside for general assessment and referral; that is, for those

cases not covered under the more restricted categories. The three assessment categories together account for almost 9 percent of the funding available from the state.

In FY 1990, DASA funds purchased 7,752 assessments in whole or in part. In 1987, DASA estimated that it took two hours at $50 per hour for a typical assessment and $50 for case management for a total of $150 for an ADATSA assessment.[121]

The costs of assessments are highly variable, depending upon the nature of that assessment and service costs in a particular county. For example, in the northeastern region of the state a general assessment and referral averages $29 an hour; but the range in that region is from $22 to $60.

Not all counties receive funding specifically for assessments. For example, 24 counties do not receive state funding specifically for DWI assessments: Adams, Grant, Spokane, Stevens, Asotin, Kittitas, Klickitat, Walla Walla, Yakima, Island, San Juan, Skagit, Snohomish, King, Kitsap, Pierce, Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, and Thurston/Mason Counties. However, there are certified DWI assessment services available in all counties except Douglas County (which receives those services through Chelan County), Pacific County and Wahkiakum County (which receives services through Cowlitz).

Certified ADATSA assessment services are found in 33 counties. Benton County ADATSA assessments are done by Benton-Franklin Alcohol and Drug Services. Mason County receives services from Thurston County. ADATSA services in Pierce County are provided by the Pierce County Alliance through a direct contract with DASA.

Having an ADATSA assessment service in a county does not guarantee quick access to assessment services. In general, there are waits for both assessment and for treatment. The average wait between referral and assessment is 21 days; the wait between a determination of eligibility and treatment is 20 days.[122] In January 1992, we were told that the wait in King County for eligibility was seven to 14 days, for assessment was four to eight weeks, and for treatment three to six weeks. Others described waits ranging from 14 to 30 days. A few counties said they had no waiting periods for assessments.[123]

In order to insure timely assessment of their criminal justice clients, several lower court probation agencies have certified alcohol/drug counselors on staff. In July 1991, King County had two counselors; Bellevue Municipal had six, Seattle Municipal had 15, Kitsap had 3.75, and Pierce had seven.[124]

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[121] Kohlenberg, et. al; Op. cit.

[122] Longhi, Op.cit.

[123] Medjo, Op.cit.

[124] Murray and Bell, Op.cit.

In summary, assessment services (generic, DWI and ADATSA) are available in most counties across the state. DASA's Needs Assessment showed 7,752 clients served in FY 1990. Although the assessment process is relatively brief (about one and one-half hours), the wait may be three weeks or more from referral. The wait between assessment and treatment may be another three weeks. Many assessment services keep in touch with clients who are waiting for treatment, Some provide limited outpatient treatment during the period.

Alcohol and Drug Information School (ADIS)

ADIS is a frequent referral for persons who are convicted of an alcohol related traffic offense and are not assessed as having a significant chemical dependency problem. Little of DASA's funds are expended for this purpose. When those funds are used, the cost of alcohol and drug information school ranges from $80 to $120. Many counties (28) do not use public funds for information school; they require that the person pay for his/her own participation.

Across the state there are 184 schools. Every county has at least one school and many counties have multiple locations (noted in parentheses): Adams, Asotin, Benton (2), Chelan (3), Clallam (4), Clark (3), Columbia, Cowlitz (3), Ferry, Franklin (2), Garfield, Grant (2), Grays Harbor (3), Island (3), Jefferson (2), King (46), Kitsap (11), Kittitas, Klickitat (2), Lewis (3), Lincoln, Mason (3), Okanogan (2), Pend Oreille, Pierce (24), San Juan, Skagit (3), Skamania, Snohomish (13), Spokane (14), Stevens (2), Thurston (7), Walla Walla, Whatcom (5), Whitman (2), and Yakima (9) Counties.

The number of program slots and the number of persons served during a year are not known. The duration of program is eight to 15 hours.

RESIDENTIAL SERVICES

Detoxification services are one form of residential services. There are perhaps 930 beds currently available in Washington. These serve approximately 14,000 people per year. Detoxification services are essentially local services. More information on detox services and the problems associated with those services are in Section 6: Barriers.

All residential services are provided by direct contracts between the service provider and DASA. These services are designed to serve clients throughout the state, but people in a community where these services are located perceive these services to be local. In FY 1990, 6,258 out of a possible 176,362 clients (3.6%) were served in residential services (other than detox) for an average cost of $1,493.[125]

[125] Kohlenberg et al, Op.cit.

Intensive Inpatient Treatment Services

Intensive inpatient treatment "provides a concentrated residential program consisting of a combination of education, individual therapy, group therapy and related activities to detoxified alcoholics and addicts."[126] These services can only last 30 days per person.

DASA contracts for intensive inpatient treatment in 10 counties: Clark, Cowlitz, King, Kitsap, Pierce, Skagit, Spokane, Walla Walla, Whatcom, and Yakima Counties. Another six counties, Chelan, Clallam, Franklin, Kittitas, Snohomish, and Thurston have certified providers of this service. Grays Harbor County has this service for alcohol abusers, but not for drug abusers.

In the ADATSA study, Longhi reports 263 intensive inpatient beds for 1989. Almost 4,000 ADATSA clients entered intensive inpatient treatment during 1989. On November 14th of that year, 92 percent of those beds were in use. The average stay for all referrals was 17 days. The average length of stay for those who entered treatment was 24 days. The difference between these is attributable to the fact that a large percentage of clients do not show.

Intensive outpatient clients are usually unemployed white male alcoholics (68%) or cocaine addicts (16%), receiving ADATSA funded treatment (86%) for a long standing dependency. See Table 12 for the breakout of primary dependency by treatment modality.

Seventy-four percent of FY 1990 intensive inpatient clients completed their treatment. The typical successful client spent three to four weeks in treatment; unsuccessful clients spent less than two weeks.[127]

DASA information on bed usage for the 1992-93 biennium indicate that, in the first half of FY 1992, 19 agencies provided 283.2 beds at an average reimbursement rate of $52.94 per bed day (See Table 10). Given this number of beds, if all intensive inpatient clients stayed the maximum period (30 days), about 3,398 clients could be served in FY 1992.

Recovery House Services

Recovery houses offer treatment in a residential setting which aid in the "adjustment to abstinence and ... to engagement in occupational training, gainful employment, or other community activities."[128] Recovery house services are designed to follow intensive inpatient treatment. However, a noticeable number of

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[126] WAC 275-19-020.

[127] Wickizer and Maynard, Op.cit.

[128] Ibid.

ADATSA clients enter recovery house programs directly. In 1989, just over 25 percent of the ADATSA clients entered a recovery house directly. These services are expected to last 60 days or less.

DASA funded recovery house services for alcohol and drug abusers are located in nine counties (Clark, King, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, and Yakima Counties). There are three recovery house programs solely for alcohol abusers in King, Snohomish and Yakima Counties. There are recovery beds in approximately one-third of all counties.

The ADATSA report shows 197 recovery beds, operated by 15 agencies in 1989. On November 14, 1989, 93 percent of these beds were in use. If treatment lasted the maximum period of 60 days, then 1,182 persons participated in recovery treatment during 1989.

Recovery house alcohol clients tend to be unemployed, somewhat older men, with longer histories of dependency. Recovery house drug clients were usually unemployed, receiving ADATSA funded treatment for a more recent addiction to cocaine (52%), heroin (17%), or marijuana (16%).

Recovery house clients whose primary dependency was on alcohol had high rates of completion; 64 percent finished treatment. Clients spent an average of three months in treatment. On average, those discharged without completing treatment left within a month.

Clients whose primary dependency was on drugs did more poorly. Only half of the drug dependent clients successfully completed treatment. Their average lengths of stay were comparable to those for alcoholic recovery house clients.[129]

DASA information on recovery house bed usage for the 1992-93 biennium indicate that 15 agencies provide 199.3 beds at an average reimbursement rate of $30.25 per bed day. (See Table 10) Three-fourths of these beds will probably be used by persons coming from intensive inpatient treatment and one-fourth by people entering directly. If all clients stay the maximum time (60 days), then about 1,164 persons will be served during the year.

Extended Care Recovery House Services

Extended care recovery house services are facility based services similar to those described above, except they are designed to last 90 days. They may be extended another 90 days.

The ADATSA study reports there were 191 extended care beds in 1989. On November 14, 1989, the extended care programs were at 96 percent of capacity.

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[129] Wickizer and Maynard, Op.cit.

This biennium there are 196 beds in two extended care facilities: Cedar Hills in King County with 136 beds and Booth House in Spokane County with 60 beds. (See Table 10.) The reimbursement rate per day is $24.97. If the duration of the program is 90 days, 784 persons may be served during the year.

Long-Term Residential Treatment Services

Long-term residential care and treatment is designed for chronic alcoholics and drug addicts with "impaired self-maintenance capabilities, needing personnel guidance and assistance..." The alcoholics can be placed there "under or in lieu of the involuntary commitment law." [130]

These programs are different from recovery house services described above. Long-term care can be divided into the drug residential program which runs a maximum of 180 days, and a program for Mentally Ill Chemical Abusers (MICA) which runs 90 days.

Long term residential care for drug abusers is available in Cowlitz County and in King County at four facilities operating on the therapeutic community model: Genesis House, and Seadrunar, Phase I in Georgetown, Phase II on Capitol Hill, and Phase III on Queen Anne. There are also two facilities in Spokane, one for women.

The long term MICA program has 19.6 beds, all in King County. The maximum stay for Axis I patients is 90 days for treatment. There is another option for clients who are suspected of both mental illness and chemical dependency. They may be admitted to a maximum of 30 days of differential diagnosis. If they are found to have both diagnoses, they are admitted to the MICA program for 90 days. It is possible to spend 120 days at this facility, but one would have been in both programs.

ADATSA study data on long term residential services indicate that in 1989 there were 95 drug residential beds of 180 days duration, operated by six agencies and one MICA program. On November 14, 1989, the drug residential programs were at 106 percent of capacity and the MICA program was at 100 percent of capacity.

Long term drug clients include a higher proportion of younger African Americans. More have become addicted during the last decade. Their primary drug dependency is cocaine (52%), heroin (24%), and amphetamines (13%). They have low rates of completion (36%) with the majority dropping out by the second month.[131]

This biennium there are a total of 102 long term residential beds. (See Table 10.)

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[130] Ibid.

[131] Ibid.

If every client stayed for the full period, the drug residential programs could take 166 clients a year and the MICA program could take 78 clients a year. So the annual total of clients treated in long term residential programs could be 244. The average reimbursement rate for drug residential treatment is $42.96 per day, and for MICA is $75.07 per day.

There is one long term residential (extended care) facility for alcoholics to which one may be involuntarily committed. This facility, located in Skagit County, has a maximum stay of 60 days, with 90 days of continuing care for a total treatment period of 150 days. This facility has a capacity of 45 beds, and is almost always full. These beds are not included in this assessment. The type of client accepted at this facility has a long history of alcohol abuse, is severely incapacitated, and has been involuntarily committed. Although they may have an offense history, they are not part of the demand described earlier.

Summary of Residential Services

There is limited availability for publicly funded alcohol or drug residential beds. It is estimated that there is a total of 781 beds which will accommodate about 5,590 clients per year. Actual FY 1990 admissions to residential treatment totaled 6,258. This is larger than capacity since many persons admitted did not stay for the full treatment period.

Total capacity of residential services is shown by county in the following table.

TABLE 10

RESIDENTIAL BEDS BY TREATMENT BY COUNTY

COUNTY	INTENSIVE INPATIENT	RECOVERY HOUSE	EXTENDED CARE	LONG TERM RESIDENTIAL	TOTAL BY COUNTY
Clark	8.3	15.0			23.3
Cowlitz	4.0			12.0	16.0
King	60.8	66.4	136.0	68.7	331.9
Kitsap	66.3				66.3
Pierce	61.4	8.8			70.2
Skagit	2.0	15.3			17.3
Snohomish		32.0			32.0
Spokane	17.0	14.8	60.0	21.8	113.6
Thurston		16			16.0
Walla Walla	1.6	9.0			10.6
Whatcom	3.4	13.0			16.4
Yakima	58.4	9.0			67.4
TOTAL BY TREATMENT	283.2	199.3	196.0	102.5	781.0

Table 11, below, summarizes known information about capacity, admissions, completion rates, and reimbursement rates for publicly funded residential services.

TABLE 11

PUBLICLY FUNDED RESIDENTIAL SERVICES: FY 1992

SERVICES	ESTIMATED ANNUAL FTE ADMISSIONS	ACTUAL CAPACITY (BEDS)	DURATION	COMPLETION RATES	REIMBURSEMENT RATE
Intensive inpatient	3,398	283.2	30 days	74%	$52.94
Recovery house	1,164	199.3	60 days	61%	$30.25
Extended care	784	196	90 days	57%	$24.97
Long term residential (drug)	166	82.9	180 days	36%	$42.96
Long term residential (MICA)	78	19.6	90 days	N/A	$75.07

COMMUNITY-BASED SERVICES

Outpatient services are generally funded through contracts between the counties and DASA. In FY 1990, 24,811 out of 465,062 people estimated to need treatment (5.3%) were served in outpatient services funded by DASA.[132] It is likely that this report considerably underestimates the outpatient services actually provided because local agencies augment DASA funds with monies from other sources, such as United Way, insurance payments and client funds.

Intensive Outpatient Services

Intensive outpatient services, whether for the alcohol or drug abuser, are a concentrated program of education, individual and group therapy and other activities, involving both the abuser and his/her family. These services are funded by hours of service, not to exceed 72 hours in a 90 day service period.

Intensive outpatient treatment for alcohol and drug abusers is offered in all counties except Adams, Asotin, Columbia, Douglas, Ferry, Garfield, Klickitat, Lincoln, Okanogan, Pend Oreille, and Wahkiakum.

[132] Kohlenberg, et al, Op.cit.

Clients of intensive outpatient services are more often alcoholics (78%) or cocaine abusers (12%). Over half have been referred by the courts. Only 22 percent complete treatment.

Intensive outpatient services are limited. As of January 1992, DASA FY1992 contracts with counties totaled $942,259. The average reimbursement was $17.75 per hour, or $426 for an average month. This would provide 72 hours of service for at least 737 clients per year. Given the duration of treatment, 184 people could be receiving intensive outpatient services at any one time.

However, at least 24 percent of outpatient services are funded with non-state monies and half the clients pay a share of the treatment costs. Hence, the number of potential clients derived using DASA budget levels is considerably smaller than the number who are actually being served.

Outpatient Treatment Services

Two types of outpatient services are included in the DASA county contracts. One is for adult outpatient services, and the other for ADATSA outpatient services. These are combined for the purposes of this discussion. Both are a less intense version of those described above. Regular outpatient treatment is offered in all counties except Douglas and Wahkiakum.

These services include both individual and group counseling. The hours per week and the specific activities vary from week one to week twelve. The proportion of group therapy hours are higher than those in the intensive outpatient program.

The average county contract pays $29 an hour for outpatient treatment. Alcohol/drug abuse program coordinators in most counties stated that outpatient treatment costs them on the average $250 a month, or $750 per client for the 90 days.

The ADATSA report data suggest that, in 1989, 3,644 persons received outpatient services. Most had also had some form of inpatient service. The ADATSA contracts for FY 1992 are for 3,422 persons a year. The ADATSA study data suggests clients receive between two to three hours per week.

Clients of adult and ADATSA outpatient services are also likely to augment the cost of their treatment although they contribute less than intensive outpatient clients do. They are usually dependent on alcohol (71%) or cocaine (12%). A third have been referred by the courts. About a third complete treatment.

DASA FY 1992 contracts with counties totaled $6,544,052 for adult and ADATSA outpatient services. At an average reimbursement rate of $750 for 90 days of treatment, this will provide outpatient services to an estimated 8,725 adult and ADATSA clients annually. At any one time the combined capacity of those services is about 2,181.

Summary

All outpatient treatments have a publicly funded capacity of 2,365 at any one time. DASA funded outpatient FTE admissions total 9,462. Estimated capacity, admission, completion rates and reimbursement rates are shown in Table 12.

TABLE 12

PUBLICLY FUNDED OUTPATIENT SERVICES: FY 1992

SERVICES	ESTIMATED ANNUAL FTE ADMISSIONS	ESTIMATED MINIMUM CAPACITY (SLOTS)	DURATION	COMPLETION RATES	REIMBURSE-MENT RATE PER MONTH
Intensive outpatient	737	184	90 days	22%	$426
Regular and ADATSA outpatient	8,725	2,181	90 days	34%	$250

Methadone Treatment

Methadone maintenance is a special form of outpatient treatment. It "provides methadone or other approved drugs as a substitute for opiates, in addition to counseling and other types of psychological and social therapy...."[133] According to WAC requirements, the counseling portion of the program can be as high as 24 hours of counseling a year with more hours in the first three months and decreasing amounts thereafter.

In FY 1990, 2,347 clients were served in methadone treatment. Methadone treatment is available in King, Pierce, Spokane and Yakima counties.

DASA treatment data show that almost 300 persons were admitted to methadone treatment in the first half of 1991. DASA contracts with counties were based on an estimated annual expenditure of $949,598.

Publicly Funded Treatment in Prisons

As noted in Section 4: Publicly Funded Treatment System, the Department of Corrections contracts with two agencies to provide substance abuse treatment services to its inmates. Last year 1,593 inmates were admitted to treatment. 1,369 completed

[133] Ibid.

treatment, an 86 percent completion rate. Participants in prison-based treatment programs are shown in the following table.

TABLE 13

DEPARTMENT OF CORRECTIONS
CHEMICAL DEPENDENCY TREATMENT PROGRAM: FY 1991

LOCATION	ENTERED	COMPLETED	COMPLETION RATE
Clallam Bay Corrections Center	102	91	89%
Cedar Creek Corrections Center	48	36	90%
Eastern Washington Pre-Release	175	143	82%
Indian Ridge Corrections Center	47	46	98%
Larch Corrections Center	40	36	90%
McNeil Island Corrections Center	104	82	93%
Olympic Corrections Center	102	97	95%
Pine Lodge Corrections Center	63	57	90%
Tacoma Pre-Release	221	205	93%
Twin Rivers Corrections Center	83	78	94%
Washington Corrections Center	107	96	90%
Washington Corrections Center for Women	112	93	83%
Washington State Penitentiary	296	228	77%
Washington State Reformatory	69	57	83%
WSR Farm	24	21	87%
Total	1593	1369	86%

SUMMARY

The publicly funded substance abuse treatment system described here includes residential treatment (781 beds), outpatient treatment (2,366 slots) and prison-based chemical dependency treatment (1,593 inmates) per year. The residential and outpatient treatment is distributed across the state. (See Table 15) Together these programs serve at minimum 16,648 clients per year. Since some clients are served by more than one program, this is not an unduplicated count. Outpatient services especially serve many clients whose treatment is partially provided by public funds, so the total number served

is probably considerably larger. DASA data indicate 31,069 served in both types of programs.

Alcohol and drug clients use the various types of treatment modalities in different ways. Table 14 shows how these two groups were distributed between programs during the fourth quarter of 1990.

TABLE 14

TREATMENT MODALITIES BY PRIMARY DEPENDENCY
FOR CLIENTS DISCHARGED DURING FOURTH QUARTER 1990

TREATMENT MODALITY	ALCOHOL	DRUG	TOTAL
Intensive inpatient (short term)	913	430	1343
Intermediate term (recovery house)	275	131	406
Long term	64	126	190
Intensive outpatient	840	237	1077
Regular outpatient	2098	773	2871
TOTAL	4130	1757	5887

TABLE 15

CAPACITY OF PUBLICLY FUNDED SUBSTANCE ABUSE TREATMENT BY COUNTY

COUNTY	INPATIENT TREATMENT CAPACITY		OUTPATIENT TREATMENT CAPACITY	
	TOTAL ADMISSIONS	BEDS	ESTIMATED FTE ADMISSIONS	ESTIMATED SLOTS
ADAMS	0.00	0.00	39.70	9.92
ASOTIN	0.00	0.00	58.86	14.71
BENTON	0.00	0.00	420.94	105.23
CHELAN	0.00	0.00	156.75	39.19
CLALLAM	0.00	0.00	125.78	31.45
CLARK	169.60	23.30	270.32	67.58
COLUMBIA	0.00	0.00	32.20	8.05
COWLITZ	72.00	16.00	244.74	61.18
DOUGLAS	0.00	0.00	0.00	0.00
FERRY	0.00	0.00	44.46	11.12
FRANKLIN	0.00	0.00	0.00	0.00
GARFIELD	0.00	0.00	21.19	5.30
GRANT	0.00	0.00	118.15	29.54
GRAYS HARBOR	0.00	0.00	103.21	25.80
ISLAND	0.00	0.00	96.06	24.02
JEFFERSON	0.00	0.00	68.62	17.16
KING	1617.89	331.90	2034.91	508.73
KITSAP	795.60	66.30	120.56	30.14
KITTITAS	0.00	0.00	57.06	14.27
KLICKITAT	0.00	0.00	61.56	15.39
LEWIS	0.00	0.00	97.82	24.45
LINCOLN	0.00	0.00	37.67	9.42
MASON	0.00	0.00	0.00	0.00
OKANOGAN	0.00	0.00	78.92	19.73
PACIFIC	0.00	0.00	60.36	15.09
PEND OREILLE	0.00	0.00	41.83	10.46
PIERCE	789.60	70.20	1354.66	338.67
SAN JUAN	0.00	0.00	53.40	13.35
SKAGIT	115.80	17.30	242.50	60.63
SKAMANIA	0.00	0.00	34.05	8.51
SNOHOMISH	192.00	32.00	903.73	225.93
SPOKANE	576.40	113.80	1123.01	280.75
STEVENS	0.00	0.00	76.48	19.12
THURSTON	96.00	16.00	321.78	80.45
WAHKIAKUM	0.00	0.00	0.00	0.00
WALLA WALLA	73.20	10.60	103.90	25.98
WHATCOM	118.80	16.40	250.20	62.55
WHITMAN	0.00	0.00	77.50	19.38
YAKIMA	754.80	67.40	529.81	132.45
STATE	5591.69	761.00	9462.70	2365.67

Estimates outpatient full time equivalent admissions are based on FY 1992 county contract dollars for intensive outpatient, adult outpatient, and ADATSA outpatient services at $1,238 for 90 days of intensive and $750 for outpatient treatment. Based on a complete turnover every 90 days, estimated slots are one-fourth the admissions.

Overall estimated minimum capacity and annual FTE admissions is shown in Table 16.

TABLE 16

ESTIMATED MINIMUM CAPACITY OF PUBLICLY FUNDED TREATMENT PROGRAMS

SERVICE	ESTIMATED MINIMUM CAPACITY	DURATION (DAYS)	ESTIMATED ANNUAL FTE ADMISSIONS
RESIDENTIAL SERVICES			
Intensive Inpatient	283	30	3,398
Recovery House	199	60	1,164
Extended Care	196	90	784
Long Term Resident - Drug	83	180	166
Long Term Resident - MICA	20	90	78
OUTPATIENT SERVICES			
Intensive Outpatient	184	90	737
Regular & ADATSA Outpatient	2,181	90	8,725
DOC PROGRAMS			
Prisons	1,197		1,197
Pre-release	396		396
TOTAL	4,739		16,645

BARRIERS TO SUFFICIENT TREATMENT FOR OFFENDERS

INTRODUCTION

The literature on substance abuse treatment for offenders suggests several barriers to providing sufficient treatment. The first and most obvious is the absence of enough resources for any kind of treatment and specifically, for substance abuse treatment. As the authors of a federal study of prison treatment options noted, the community has limited publicly funded slots to begin with, and offenders must compete for those slots.[134]

One reason for the deficit in treatment dollars is doubt about treatment viability; that is, does it work? Doubts about offender treatment effectiveness have been strongly reinforced by the scientific community. First, Martinson and then, the National Academy of Science examined studies of treatment effectiveness and concluded that few found treatment to have a positive impact on offender behavior.[135]

As already reported in Section 2, recent studies of substance abuse treatment for offenders guardedly suggest more positive outcomes if certain program characteristics are present or certain abuse groups are the target. For example, the preferred program elements in prison treatment include clear rules that are quickly enforced; concerned and credible staff; provision of tools for avoiding further criminal behavior; and use of community resources. Or, when heroin addicts are the target population, the programs appear to be somewhat more effective than when the target population is composed of offenders with dependency on other substances in addition to heroin.[136]

Even if the treatment effects were clear, members of both the criminal justice and the treatment communities would likely remain resistant to the substance abuse offender population and to their treatment. As noted in recent studies of prison treatment, there are several difficulties. For one, there is a conflict between the goals of criminal justice system and the treatment system. The justice system intends to punish the offender; the treatment system intends to stabilize or rehabilitate.[137]

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[134] Mark V. Nadel, Drug Treatment: State Prisons Face Challenges in Providing Services, United States General Accounting Office, September 1991.

[135] D. Lipton, R. Martinson, and J. Wilks, The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies; New York: Praeger Publishers, 1975. and Sechrest, White, and Brown, Op.cit.

[136] Gerstein and Lewin, Op.cit.

[137] Chaiken, Op.cit.

Furthermore, the two communities have different tolerances for the offender as a client. The justice system is accustomed to the offender, realistic about his/her behavior, and prepared to respond to inappropriate behavior. The treatment community is not. On the other side, the treatment community is accustomed to addictive behavior. It is prepared to view the behavior as symptomatic of a disease and the client as someone who can be stabilized or rehabilitated. In this case it is the justice system that has the lower level of tolerance.

Restrictions on the number of offenders, particularly felons, in community based programs is not uncommon and caution about accepting the offender client is probably more pervasive than some would like to admit.

Experience elsewhere suggests that these difficulties can be overcome if there is some agreement on key issues. It is important to note that joint corrections/treatment program efforts have proven effective when common goals are established and similarities, not differences, are emphasized. Some key issues include: how participants are selected, i.e. who is appropriate for this treatment, how long treatment should last, what is appropriate behavior while in treatment, and how to expel or otherwise sanction participants who fail to behave appropriately.

Treatment for drug addicts should last at least 90 days. The length of treatment for alcohol dependency varies with chronicity. Most agree that inpatient treatment, even within an correctional institution setting, needs to be linked to community aftercare. Under those circumstances the often poor coordination between criminal justice personnel, particularly community supervision staff, and treatment providers and/or between prison or jail staff and community supervision staff can be a barrier to successful treatment.

Too often the assumption is that it is sufficient to suggest that an offender participate in AA or NA or that discharge planning can conclude when the offender client knows what outpatient resources exist and how to make contact with those resources. Admittedly, limited outpatient treatment resources can make these forms of discharge planning a necessity.

There is also offender resistance to treatment. Gerstein and Lewin[138] suggest that people nearly always enter treatment under pressure, either due to personal problems such as physical or mental health, or social problems arising from the law, the family, other drug users or dealers, or sudden loss of income. Treatment is demanding; it imposes controls and requires work to overcome social and psychological deficiencies.

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[138] Gerstein and Lewin, Op.cit.

Chaiken notes the difference between forced and legally required treatment. She suggests that a legal requirement for treatment is workable as long as the offender has some choice between treatment and another sanction. She also notes that positive incentives can be used as well, but often are not.

Chaiken suggests four primary barriers to in-prison treatment. These are also barriers to community-based treatment. The primary barriers are: the ever changing priorities for the use of treatment funding, i.e., what type of program do we need; the constraints on those funds; treatment viability; staff and offender resistance.

Doubts about program effectiveness, limited resources, and resistance to the population and to its treatment are generic barriers to sufficient substance abuse treatment for Washington's offender population. There are other difficulties from the perspective of those providing detoxification services, from the perspective of the providers of inpatient and outpatient treatment, and from the perspective of the criminal justice professionals.

BARRIERS STEMMING FROM DETOXIFICATION SERVICES

Detoxification services are designed to provide care and treatment during the period of recovery from acute intoxication or withdrawal. Depending upon the degree of chemical dependence, withdrawal can be an important or insignificant phase of treatment. If it has not already occurred, then it happens when the client enters the program.

Thirteen counties (Chelan, Clark, Cowlitz, Franklin, King, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, and Whatcom Counties) have alcohol and drug abuse acute detoxification services and eight (Franklin, Grays Harbor, Kitsap, Skagit, Snohomish, Spokane, Whatcom, and Yakima) have sub-acute services for both alcohol and drug abuse detoxification. Two additional counties (Grays Harbor and Yakima Counties) have alcohol acute detoxification.

Some counties receive block grant funds for detox services, which they administer. In many smaller counties, DASA contracts directly with a local hospital for detox beds. Gerstein and Lewin[139] suggest that medical detoxification in a hospital setting is not needed for all drug abusers. DASA data on treatment days suggest that on any one day there may be 930 detox beds across the state, but the exact number is not known.

Thus, detoxification services were not detailed in this document. It is important to note that DASA records show detox facilities served 13,814 people during FY 1990

[139] Ibid.

out of a possible 465,062 clients for a use rate of 2.97. This is the lowest use rate of any of the DASA funded services included in the needs assessment and would suggest that detox services are the least available of any publicly funded service.

There are several explanations for this rate. The number of available beds is one critical issue. Only King County has a facility specifically for detoxification. This facility has 85 beds. Currently, there is discussion of providing a detoxification facility in Yakima County. In other counties detox is a hospital based treatment. Smaller hospitals with slender staff resources are reluctant to take some detoxifying persons. For another, detox can and does happen outside those facilities, even in other DASA supported treatments. The local jail is also a place where offender detoxification occurs. Jail staff are expected to have training in detoxification screening and service provision. Still, in most jails the services are not very sophisticated or even sufficient. As one jailer described the task of overseeing detoxification, "we make sure they do not drown in their own vomit."

Jail staff complain about the number of DWI offenders and persons serving weekend sentences who appear for their short jail stays as intoxicated as possible. Providers of substance abuse treatment services see the same behavior when the offender client is a coerced participant or when the heavily addicted client has not been assisted through withdrawal. Thus, a community's limited detoxification services can affect the number accepted by the next tier of providers.

BARRIERS PERCEIVED BY TREATMENT PROVIDERS

Inadequate detoxification services were not among the critical issues raised during the WAPA discussions between the treatment community and criminal justice professionals or in our discussions with providers. They have other specific concerns regarding public pay clients and specifically criminal justice clients. The following material comes primarily from three sources: unpublished material from the Sentencing Guidelines Commission survey of criminal justice professionals regarding alternative sentencing options; telephone interviews with selected county coordinators and treatment providers; and Washington Association of Prosecuting Attorneys' Treatment Resources for Criminal Offenders.

In brief, the treatment community asserts that the criminal justice agencies refer clients who are not good candidates for treatment and expect the treatment agency to provide quasi-supervision. For this service treatment agencies receive less than the actual cost of treatment.

Treatment providers further contend that the criminal justice system places clients who are too difficult to handle. Court ordered clients are seen as unwilling clients who have accepted treatment as a way to avoid jail. Providers concur with Chaiken that

coercion reduces the court ordered client's motivation and thus his or her ability to benefit from treatment. However, others have argued that court imposed treatment is not necessarily a barrier to positive outcome.

These clients are seen as inappropriate in another way. Persons can be placed on deferred prosecution for two years. Yet ADATSA funded treatment cannot last longer than six months. Orders for treatment on deferred prosecution should take into account these limits on the duration of ADATSA funded treatment.

Treatment providers acknowledge there are delays in admissions resulting from insufficient treatment capacity. They agree that being placed on a waiting list makes it hard to hang onto any substance abuse client long enough to get them into treatment.

Requiring treatment providers to both treat the substance abuse and in many cases to monitor behavior, that is, to act as probation officers, is a particular cause for concern. This concern is exacerbated when the criminal justice system fails to sanction inappropriate behavior or does so too slowly.

Funding is another contentious issue. The actual cost of treatment is often more than most offender clients can pay and the reimbursement rates from the public sector are also less than the actual cost. When available funding and true unit costs set the amount of treatment to be provided, then the level of treatment is quite low, perhaps too low to expect positive benefits except with the most motivated client. Most offender clients do not fall into that group.

Treatment providers have other clients to serve, including some who are also eligible for public funded treatment. They wonder if they are spending too much of their own and the public resources on offender clients. Given their perception that the offender is not always the "best" client, it is not surprising that they wonder about the share of public substance abuse funding going to the offender client.

These concerns are not unique to Washington treatment providers. They are voicing common themes that occur across the country in the provision of substance abuse treatment to offender populations.

BARRIERS PERCEIVED BY THE CRIMINAL JUSTICE SYSTEM

Some substance abuse treatment is required by statute. For example, anyone convicted of a second DWI offense must be assessed and, when determined appropriate, receive substance abuse treatment.

When treatment is not required by statute, but the offender has a substance abuse problem, why do judges and attorneys not recommend treatment with even

greater frequency? For one, treatment is not recommended by the community supervision officer or the probation officer. Treatment is simply not an alternative noted in the pre-sentence investigation report (PSI). Treatment is a missing option for the same reasons already noted above.

Furthermore, the professionals in the criminal justice system lack confidence in the treatment alternatives or they do not see those alternatives as meeting other goals of the criminal justice system, i.e. to punish the offender for the offense or to deter future offenses committed by the offender or others. More specifically they do not recommend or order treatment because of the aforementioned delays in assessing the need for treatment and delays in admission to treatment.

The criminal justice professionals also note the absence of appropriate treatment, particularly for some types of offenders. Just as the treatment professionals are reluctant to take some offenders because they are too difficult to manage, the criminal justice professionals are reluctant to refer because the treatment does not seem sufficiently structured for some offender clients.

Work loads or overloads make it difficult (particularly for many lower court probation agencies) to assess the presence of substance abuse and to recommend treatment in the PSI. It is even more difficult for them to monitor offender behavior while they are in substance abuse treatment. The capacity or the functions of those agencies will need to change before they can identify all who might benefit from treatment or stop relying on treatment agencies to perform monitoring functions once an offender has been ordered to treatment.

Offenders themselves are often resistant to treatment. Treatment places new demands. It is not an easy time. They do not "need it." In addition, they are concerned about costs and their ability to pay. The fees are often seen as too high or the offender cannot become eligible for ADATSA or other public support.

When the individual offender fails to get into treatment or to find funding for treatment, s/he is out of compliance with the court order. The alternative is usually jail. Probation or community supervision officers grow reluctant to recommend treatment when limited capacity results in failures to comply with court requirements. In addition, some offenders fail to complete treatment. For them the alternative is also jail. Going to jail in the first place may be more appealing to many offenders. The result in all these situations is an increased use of non-treatment sanctions. For the criminal justice professional, there is a growing disinterest in ordering treatment when too many fail to meet the terms of the order for whatever reason.

COMPLETION RATES

Being forced to recognize their addiction may make offenders better conditioned to accept and complete treatment. However, delays in entering treatment can affect completion rates, particularly if the potential client is reluctant.

ADATSA calculated waiting periods both for assessment and for entry into treatment services. As noted previously, the average wait between referral and assessment is 21 days, and the wait between eligibility and treatment is 20 days.[140] During this period half of the potential clients drop out.

Of those who enter treatment, not all complete it. Completion for discharged clients is defined by staff in accordance with DASA guidelines. The guidelines specify that a treatment plan defines goals and time lines with successful completion signaling compliance with the plan. Failure to complete may have occurred because the client did not comply with the plan for treatment or because s/he has an inappropriate admission, or because of transfer to another program. The dropout rates vary by modality and by primary dependency. (See Table 17) Residential programs have higher completion rates than outpatient programs, and alcoholics have higher completion rates than drug addicts. The factors which influence entrance and completion rates are not yet well defined. They, too, are barriers to sufficient treatment.

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[140] Longhi, Op.cit.

TABLE 17

COMPLETION RATES BY MODALITY FOR
CLIENTS DISCHARGED FOURTH QUARTER 1990[141]

TREATMENT MODALITY	NUMBER ENTERING	NUMBER COMPLETING	PERCENT COMPLETING
Intensive inpatient	1343	998	74%
Recovery house			
Alcohol	309	197	64%
Drugs	97	49	51%
Long term residential			
Alcohol	58	33	57%
Drugs	132	47	36%
Intensive outpatient	1077	233	22%
Outpatient	2871	965	34%

SUMMARY

The national perspective on the barriers to substance abuse treatment suggests that the most significant barriers are too few resources and thus too few treatment slots. Those are factors in Washington as well.

Additional important barriers are: doubts about treatment viability, difficulties in designing programs that identify appropriate clients and which establish clear rules for behavior and methods for enforcing rules quickly, and the lack of linkages between the treatment and criminal justice systems and between the inpatient and the outpatient portions of the two systems.

Finally, no barrier is as great as the one facing the offender who has a court order for treatment but who cannot pay for that treatment, or become eligible for public funding, or find an appropriate treatment to enter.

[141] Wickizer and Maynard, Op.cit.

COST OF PROVIDING TREATMENT SERVICES

REIMBURSEMENT RATES FOR PUBLICLY FUNDED SERVICES

Useful cost information about treatment services is only available for publicly funded services. In the absence of sufficient data from other sources, we use the ADATSA treatment modalities and DASA reimbursement rates in this and other sections of the report to illustrate the cost of providing substance abuse treatment to offenders.

There are seven basic treatment modalities for which reimbursement rates can be reported or estimated. These are: intensive outpatient, regular outpatient, intensive inpatient, recovery house, extended care drug residential, extended care (alcohol) recovery house, and MICA treatment.

Reimbursement rates for residential care can be reported directly. Reimbursement rates for outpatient care are affected by the number of hours of treatment provided per patient. In this analysis it is assumed that intensive outpatient services provide an average of six treatment hours per week. For regular outpatient treatment the average number of treatment hours per week is estimated to be 2.5. Based on these assumptions, the average reimbursement rates per person are as follows:

TABLE 18

REIMBURSEMENT RATES BY TREATMENT MODALITY

TREATMENT MODALITY	DAILY RATE	DAYS	TOTAL RATE
INTENSIVE OUTPATIENT	14.17	90	1,275
REGULAR OUTPATIENT	8.33	90	750
INPATIENT	52.94	30	1,588
RECOVERY HOUSE	30.25	60	1,815
EXTENDED CARE DRUG RESIDENTIAL	42.96	180	7,733
EXTENDED CARE RECOVERY HOUSE (ALCOHOL)	24.97	90	2,247
MICA TREATMENT & DIAGNOSIS	75.07	30	2,252
MICA TREATMENT	75.07	90	6,756

OFFENDER UTILIZATION OF SERVICES

The treatment modalities discussed in the previous paragraph can be combined in various ways in what ADATSA calls "paths." The primary paths funded by ADATSA are: outpatient (90 days of either intensive or regular outpatient treatment); the 30/90

path (30 days intensive inpatient followed by 90 days outpatient); the 30/60/90 path (30 days intensive inpatient followed by 60 days in recovery house followed by 90 days outpatient); the long term residential path (either 180 days in extended care drug residential or 90 days in extended care alcohol residential followed by 90 days in recovery house or 90 days outpatient treatment); or the MICA path (30 days in MICA diagnosis and treatment followed by 90 days in MICA treatment followed by 60 days in recovery house or 60 days outpatient treatment).

Table A6.8 in the ADATSA Report identifies criminal justice involvement by treatment path. While it may be the case that criminal justice involvement is under reported in this table, there is no reason to suspect that there is systematic bias in reporting by treatment path. Consequently, the data reported in this table should be a good representation of the relative use of different treatment paths by offenders.

Parole or probation status was one of the factors reported. Using the percentage of persons identified as being on probation or parole, we estimate the current relative use of treatment paths by offenders as follows:

TABLE 19

ESTIMATED DISTRIBUTION OF OFFENDERS BY TREATMENT PATH

TREATMENT PATH	OFFENDER UTILIZATION
OUTPATIENT	19%
30/90 PATH	29%
30/60/90 PATH	27.5%
EXTENDED CARE DRUG RESIDENTIAL	8%
EXTENDED CARE (ALCOHOL) RESIDENTIAL	11%
MICA	5.5%

THE COST OF TREATMENT SERVICES FOR OFFENDERS

Knowledge of the reimbursement rates by treatment modality plus knowledge of the distribution of offenders by treatment path does not tell us how much it costs to provide substance abuse treatment to offenders. What is missing is an understanding of the relationship between path utilization and modality utilization.

To further our analysis, an equation was developed to quantify this relationship. The equation relies on treatment completion data taken from the ADATSA Report and from Wickizer. In a few cases where completion data were not available, completion rates were interpolated between known points. Where the final phase of a path terminates in either one kind or treatment or another, an arbitrary 50/50 split was made between the two modalities.

The basic equation can be written as follows:

$$X_{1a} + X_{2a} + X_{3a} = 100\%$$

where X_{1a} is the percentage of offenders in Step 1 of Path a, X_{2a} is the percentage in Step 2 of Path a and X_{3a} is the percentage in Step 3 of Path a. We solve for X_{1a}, X_{2a} and X_{3a} by accounting for the difference in duration of the various steps and the percentage of offenders that complete one step and go on to the next.

For example, for the 30/90 path, if everyone who starts the 30 day program goes on to the 90 day program, we would expect 3 times as many people to be in the outpatient part of the path as the inpatient. But from the ADATSA data we know that 89 percent of those who start the first phase of the 30/90 Path go on to the second phase. Consequently, we would expect that 89 percent of 3, or 2.67 times as many people should be in the 90 day program as are in the 30 day program.

We now have two equations with two unknowns as follows:

$$X_{30} + X_{90} = 1$$

and

$$X_{90} = .89 \times 3 \times X_{30} = 2.67X_{30}$$

Solving the equations yields the result that 27 percent of those in the 30/90 path are in inpatient treatment and 73 percent are in outpatient treatment. Since we also know that 29 percent of the offenders in treatment are in the 30/90 path we know that 7.8 percent (23% of 29%) of all offenders in treatment are in 30 day inpatient treatment as part of the 30/90 treatment path.

By performing the same kind of analysis on all five treatment paths, the percentage of offenders in each modality can be derived. Table 17 shows the assumptions used in the calculations.

TABLE 20

HISTORICAL DISTRIBUTION OF OFFENDERS BY PATH

TREATMENT PATH	OFFENDER % DIST (a)	% WHO (a) START	% WHO (a) FINISH	DISTRIBUTION PATH	DISTRIBUTION TOTAL
PATH 1: OUTPATIENT	19.0%				
90 DAY OUTPATIENT					
INTENSIVE		100.0%	38.5%	27.0%	5.1%
REGULAR		100.0%	38.5%	73.0%	13.9%
PATH 2: 30/90	29.0%				
30 DAY INPATIENT		100.0%	88.7%	27.0%	7.8%
90 DAY OUTPATIENT		88.7%	49.4%	73.0%	21.2%
PATH 3: 30/60/90	27.5%				
30 DAY INPATIENT		100.0%	87.9%	23.0%	6.3%
60 DAY RECOVERY HOUSE		87.9%	61.0% b	40.0%	11.0%
90 DAY OUTPATIENT		61.0% b	28.5%	37.0%	10.2%
PATH 4: LONG TERM RESIDENTIAL					
180 DAY EXTENDED CARE DRUG RESIDENTIAL	8.0%	100.0%	28.6%	8.0%	8.0%
90 DAY EXTENDED CARE RECOVERY HOUSE	11.0%	100.0%	88.8%	53.0%	5.8%
AND					
90 DAY RECOVERY HOUSE – Alcohol		88.8%	70.2%	23.5% d	2.6%
OR					
90 DAY OUTPATIENT – Alcohol		88.8%	70.2%	23.5% d	2.6%
PATH 5: MICA	5.5%				
30 DAY TREATMENT & DIAGNOSIS		100.0%	63.0%	37.0%	2.0%
90 DAY MICA TREATMENT		63.0%	55.8% c	46.0%	2.5%
AND					
60 DAY RECOVERY HOUSE		55.8% c	48.6%	8.5% d	0.5%
OR					
60 DAY OUTPATIENT		55.8% c	48.6%	8.5% d	0.5%
TOTAL	100.0%				100.0%

NOTES

a Derived from Table A6.8 b From Wickizer data c Interpolated d Split 50/50

Adding percentages by treatment modality results in the following distribution of utilization:

TABLE 21

SUMMARY OF OFFENDER TREATMENT UTILIZATION
By Treatment Modality

TREATMENT MODALITY	TOTAL	ROUNDED
90 DAY INTENSIVE OUTPATIENT	5.1%	5%
90 DAY REGULAR OUTPATIENT	48.3%	48%
30 DAY INPATIENT	14.2%	14%
60 DAY RECOVERY HOUSE	14.1%	14%
180 DAY EXTENDED CARE DRUG RESIDENTIAL	8.0%	8%
90 DAY EXTENDED CARE RECOVERY HOUSE	5.8%	6%
30 DAY TREATMENT & DIAGNOSIS	2.0%	2%
90 DAY MICA TREATMENT	2.5%	3%
TOTAL	100.0%	100%
RESIDENTIAL PROGRAMS	46.6%	47%
NON-RESIDENTIAL PROGRAMS	53.4%	53%

Finally, this analysis of utilization, combined with reimbursement rates for the same modalities, results in a computation of the average daily cost of substance abuse treatment for offenders. By multiplying the percentage of offenders in each modality times the cost per day for each modality and summing the resulting products, a weighted average cost is obtained.

The following table shows the calculation of the average cost. Later on, this same method will be used to calculate different average costs assuming a different mix of utilization rates.

TABLE 22

AVERAGE REIMBURSEMENT RATE CALCULATION
For Offenders in Treatment

TREATMENT MODALITY	PERCENT OF TOTAL	DAILY RATE	PRODUCT
90 DAY INTENSIVE OUTPATIENT	5.0%	14.17	0.71
90 DAY REGULAR OUTPATIENT	48.0%	8.33	4.00
30 DAY INPATIENT	14.0%	52.94	7.41
60 DAY RECOVERY HOUSE	14.0%	30.25	4.24
180 DAY EXTENDED CARE DRUG RESIDENTIAL	8.0%	42.96	3.44
90 DAY EXTENDED CARE RECOVERY HOUSE	6.0%	24.97	1.50
30 DAY TREATMENT & DIAGNOSIS	2.0%	75.07	1.50
90 DAY MICA TREATMENT	3.0%	75.07	2.25
WEIGHTED AVERAGE			25.04

As can be seen from this analysis, the average reimbursement rate for offenders in substance abuse treatment is approximately $25 per day. Given the distribution of offenders in community treatment, the average stay across all treatments is 145 days for an average cost of $3,625 a treatment. The analysis on which offender distribution across treatment is found in Table 20.

Some offenders received treatment in prison at an average cost of $660 for each person entering treatment. There is no comparable treatment presently available in jails.

Given these reimbursement rates for treatment, it is possible to calculate the cost of treating all offenders who might have required that treatment in 1991. In this analysis, it is assumed that approximately 25,000 offenders per year are in need of treatment and that, with sufficient resources, half would enter treatment. With these assumptions, the total cost would have been $35,579,094.

TABLE 23

PROJECTED COSTS:
OFFENDERS WHO COULD ENTER TREATMENT IN 1991

TYPE OF PLACEMENT	NUMBER OF OFFENDERS	OFFENDERS NEEDING TREATMENT (PREVALENCE RATE)	OFFENDERS ENTERING TREATMENT	TOTAL COST OF TREATMENT
In Local Total or Partial Confinement	7,074	2,900 (41%)	1,450	$ 957,000
Under Local Community Supervision	36,674	3,521 (9.6%)	1,760	$ 6,381,812
In State Total or Partial Confinement	9,107	3,734 (41%)	1,867	$ 1,232,220
Under State Community Supervision	36,343	14,901 (41%)	7,450	$27,008,062
Total	89,198	25,056 (28.1)	12,527	$35,579,094

Some portion of this population did receive treatment in 1991. Part of that treatment was paid for with public monies. Since offender clients cannot be precisely separated from non-offender clients, the exact amount is not known.

IMPLICATIONS FOR THE FUTURE

PROJECTED INCREASE IN DEMAND FOR TREATMENT SERVICES

Demand for treatment will increase as the offender population grows. In the 1991 Capacity Study, the number of offenders under criminal justice control in Washington State was projected to increase from approximately 92,000 offenders in 1992 to about 133,000 in 1996. If the need for treatment services remains the same and the same treatment costs are applied to the increased offender population, then total future costs can be estimated.

In Section 5, "Criminal Justice Demand for Treatment Services," there were two estimates of demand for treatment services. These estimates imply significantly different prevalence rates and service utilization rates. In the following calculations, the lower of the two estimates was used. If the higher estimate were used, total estimated costs would increase by an additional $36,000,000.

TABLE 24

PROJECTED COST OF SUBSTANCE ABUSE TREATMENT
FOR ESTIMATED NUMBER OF OFFENDERS IN 1996

PLACEMENT	EST # OFFENDERS IN 1996	EST # ENTERING TREATMENT	COST per PERSON	EST TOTAL COST
Local Confinement	9,114	1,868	660	1,233,000
Local Supervision	53,519	2,569	3,625	9,313,000
State Confinement	13,183	2,702	660	1,784,000
State Supervision	57,589	11,806	3,625	42,797,000
Total	133,405	18,945	2,910	55,127,000

In 1991, for an offender population of approximately 92,000, costs for substance abuse treatment for offenders are estimated to total approximately $35,000,000. Therefore, the cost of providing the same level of service in 1996 will be about $20,000,000 more than current level (not counting increased costs due to inflation).

COST IMPLICATIONS OF DIVERSION FROM INCARCERATION

In this section, the focus of discussion is on the immediate cost consequences of diverting offenders from some form of confinement to community based residential or outpatient treatment. Note the emphasis on immediate cost consequences. The long term savings, if any, related to the reduction in repeat offense due to successful treatment is not included in this analysis. On the other hand, it should be noted that -- because of the high cost of incarceration -- even a small amount of success in treatment can result in significant savings from avoided future incarcerations.

It should also be emphasized that the alternatives discussed below are not advanced as recommendations, but rather as illustrations. Factors other than cost must be taken into account when making decisions of this importance. With this caveat in mind, there are three general alternatives which we have analyzed. Each includes both substance abuse treatment and three different forms of non-incarcerative criminal justice control. They are:

- DIVERSION FROM JAIL

  Option 1: Substance abuse treatment plus regular community supervision for all offenders.

  Option 2: Substance abuse treatment plus regular supervision for offenders in residential treatment and intensive supervision for offenders in outpatient treatment.

  Option 3: Substance abuse treatment plus regular supervision for all offenders and electronic monitoring for offenders in outpatient treatment.

- DIVERSION FROM STATE WORK RELEASE

  Option 1: Substance abuse treatment plus regular community supervision for all offenders.

  Option 2: Substance abuse treatment plus regular supervision for offenders in residential treatment and intensive supervision for offenders in outpatient treatment.

  Option 3: Substance abuse treatment plus regular supervision for all offenders and electronic monitoring for offenders in outpatient treatment.

- DIVERSION FROM MINIMUM SECURITY PRISON

  Option 1: Substance abuse treatment plus regular community supervision for all offenders.

  Option 2: Substance abuse treatment plus regular supervision for offenders in residential treatment and intensive supervision for offenders in outpatient treatment.

  Option 3: Substance abuse treatment plus regular supervision for all offenders and electronic monitoring for offenders in outpatient treatment.

In each case the analysis assumes that the duration of treatment is the same as permitted under ADATSA rules, i.e. a maximum of 180 days of treatment during any two year period. In addition, it is assumed that some period of community supervision continues beyond the 180 day treatment phase. Where more restrictive control is used for offenders not in residential treatment, the analysis assumes continuation of the more restrictive control for *all* offenders during their post-treatment phase.

Reimbursement rates and the cost of various types of treatment services for offenders were discussed in Section 6, "Cost of Providing Treatment Services." As noted there, the average cost per day to provide substance abuse treatment to any given group of people depends on the mix of services used by that group.

If we assume that offenders diverted from incarceration are placed in substance abuse treatment in the same proportions as currently prevail, then the average reimbursement rate for treatment is about $25 per day. Present treatment mix actually results in 145 days of treatment on the average. If treatment were extended to a full 180 days, then the average cost of treatment would be about $4,500. Treatment costs plus the cost of correctional control can be compared to the cost of incarceration to determine the net cost or savings accruing from any set of assumptions.

As part of the Criminal Justice System Capacity Study, average costs for various types of criminal justice control were identified. In the analysis that follows, we are interested in the cost of county jail, state work release, minimum security prisons, regular supervision, intensive supervision, and electronic monitoring. The following table summarizes the cost information from the Criminal Justice System Capacity Study for those types of placements.

TABLE 25

AVERAGE COST PER DAY PER OFFENDER
(1991 Dollars)

OFFENDER PLACEMENT	COST PER DAY SERVED	COST PER DAY SENTENCED[142]
Regular Supervision	3.01	2.00
Intensive Supervision	7.18	4.79
Electronic Monitoring	11.96	7.98
County Jail	44.48	29.65
State Work Release	47.08	31.39
Minimum Security Prison	51.86	34.58

Taken together, this information can be used to show at what point the cost of treatment plus non-incarcerative control is less than the cost of incarceration. The chart on the following page shows the accrued savings (per offender) due to suspension of incarcerative sentences of from 0 to 18 months.[143] At the same time, the chart shows the accrued cost of providing treatment plus the three types of correctional control described above. Where the cost lines intersect the savings lines, cost and savings are equal. When a cost line is lower than a savings line, costs are lower than savings. At any given time, the difference between cost and savings represents the net amount saved or expended.

Note that the break even analysis is based on the amount of sentence time suspended. It is assumed that offenders suitable for diversion would normally earn the maximum potential good time while incarcerated. The cost savings lines used in the following chart have been adjusted to account for a 1/3 reduction in time served due to good time.

As the chart shows, during the treatment phase of any of these scenarios, the cost of treatment plus correctional control is approximately equal to the cost of confinement. Consequently, significant savings accrue only for offenders who have

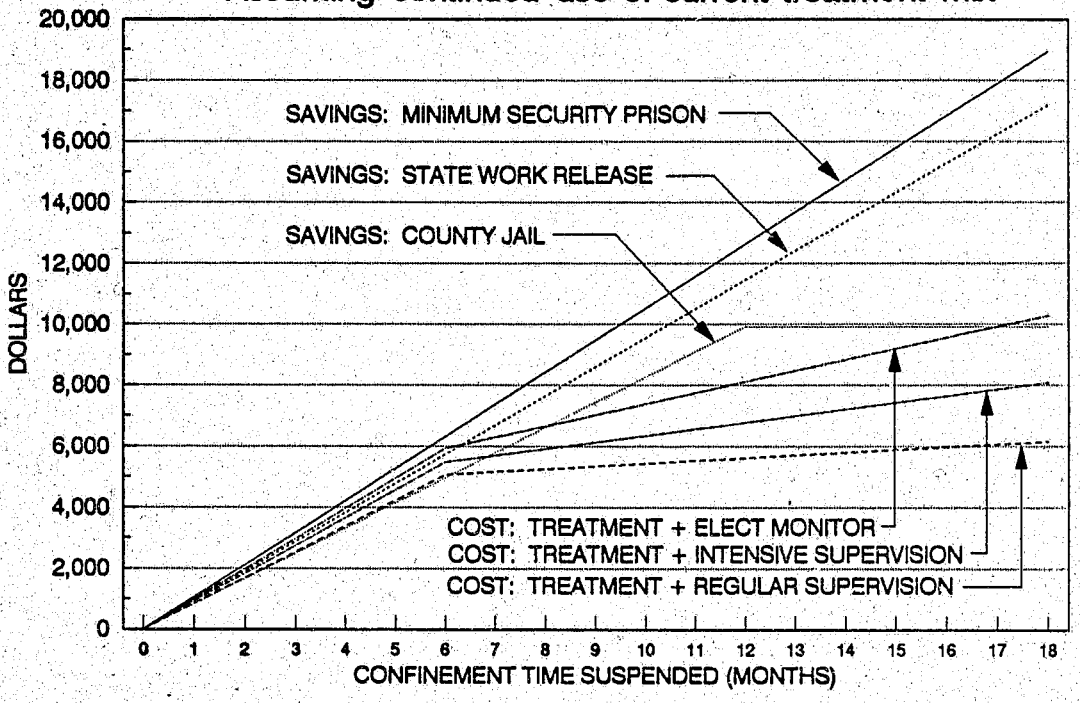
[142] Most offenders who follow inmate rules of conduct receive one day credit for every two days served. If all potential "good time" is earned, then the cost per day sentenced is two-thirds the average daily cost.

[143] By definition, sentences for jailed offenders cannot exceed 12 months. Consequently, savings related to jail diversions are maximized at 12 months and cannot increase beyond that.

suspended sentences that are longer than the time spent in treatment. The greatest savings accrue for offenders diverted from prison and for offenders whose correctional control in the community is limited to regular supervision.

TABLE 26

BREAKEVEN ANALYSIS
Cost and Savings Per Person
Assuming continued use of current treatment mix



COST CONSEQUENCES OF TREATMENT FAILURE

The previous analysis shows the cost implications of each successful diversion of an offender from incarceration to treatment. In reality, not all diversions are successful.

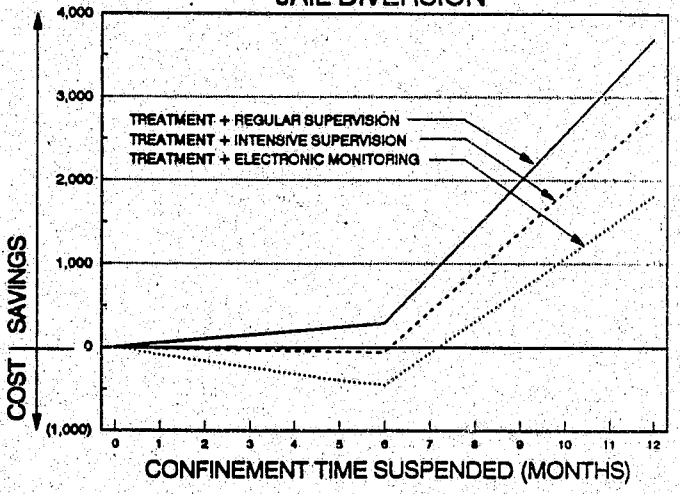
To explore the effect of treatment failures, the model used to forecast costs and savings was modified to reflect both the percentage of failures and the assumed average time to failure. For purposes of this analysis it was assumed that treatment failure means revocation and re-imposition of the suspended sentence. That is, if a person has a suspended sentence of 18 months and fails treatment after three months, s/he will spend the remaining 15 months in confinement. An actual diversion program might be defined in some other manner. Using this scenario is fiscally conservative, i.e. it results in the greatest cost impact of a treatment failure.

The primary finding of this analysis is that the fiscal consequences of treatment failure are insignificant. For example, since the average cost of treatment plus the most expensive form of correctional control used in our analysis is less than the cost of confinement in state prison, even if everyone diverted from prison failed treatment, there would be a small net savings. Only with diversion from county jail to the treatment plus intensive supervision, or treatment plus electronic monitoring, is there any appreciable net loss due to treatment failures. When the failure rate was increased from 30 percent to 50 percent, the largest change in any breakeven point for any option was only about 15 days.

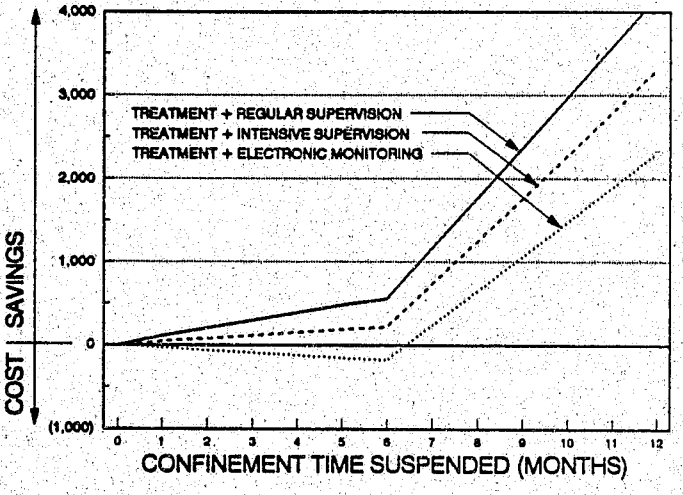
The figures at the right illustrate the cumulative financial impact of diversions from jail, state work release, and minimum security prison assuming a failure rate of 30 percent and average time to failure of three months.

In the following paragraphs we explore the consequences of changing the mix of treatment modalities to increase the proportion of offenders who are in residential treatment programs. Since residential programs cost more than outpatient treatment, the cost of failure will be greater.

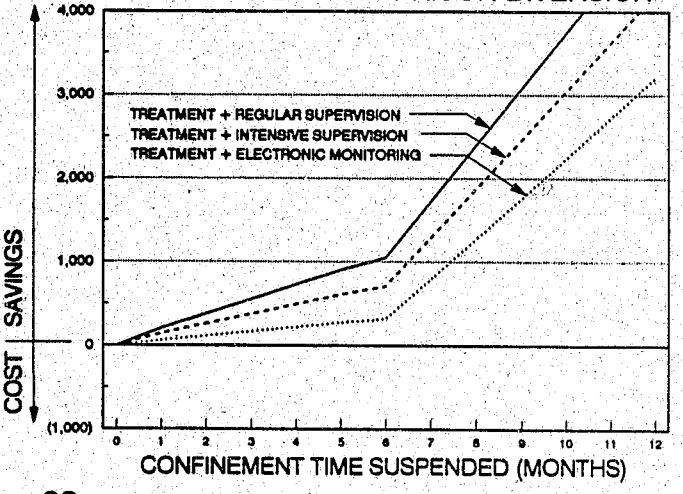
CUMULATIVE FINANCIAL IMPACT per JAIL DIVERSION



CUMULATIVE FINANCIAL IMPACT per STATE WORK RELEASE DIVERSION



CUMULATIVE FINANCIAL IMPACT per MINIMUM SECURITY PRISON DIVERSION



COST IMPLICATIONS OF INCREASING RESIDENTIAL TREATMENT

In the examples discussed above, it was assumed that the current mix of treatment modalities is continued. Under current utilization, *at any given time,* about 47 percent of the offender population is in a residential treatment setting. The remainder are in outpatient treatment. Please note that this does not mean that 53 percent of participating offenders are never in a residential setting. In fact, under the current system, 81 percent of all offenders start in some type of inpatient or residential care. It is only because the average length of stay in outpatient treatment is longer than that of residential programs that the percentage of offenders in residential programs at any given time is as low as it is.

In this section we explore the cost implications of requiring all offenders to begin treatment in a residential setting. Table 27 uses the same methodology described in Section 8: Cost of Providing Treatment Services," to calculate the percentage of offenders by treatment modality. The percentages used in the column labeled "Offender % Distribution" are illustrative only.

TABLE 27

HYPOTHETICAL DISTRIBUTION OF OFFENDERS BY TREATMENT PATH
(Note that all offenders begin treatment in a residential setting)

TREATMENT PATH	OFFENDER % DIST (a)	% WHO (a) START	% WHO (a) FINISH	DISTRIBUTION PATH	DISTRIBUTION TOTAL
PATH 1: OUTPATIENT	0.0%				
90 DAY OUTPATIENT					
INTENSIVE		100.0%	38.5%	27.0%	0.0%
REGULAR		100.0%	38.5%	73.0%	0.0%
PATH 2: 30/90	20.0%				
30 DAY INPATIENT		100.0%	88.7%	27.0%	5.4%
90 DAY OUTPATIENT		88.7%	49.4%	73.0%	14.6%
PATH 3: 30/60/90	30.0%				
30 DAY INPATIENT		100.0%	87.9%	23.0%	6.9%
60 DAY RECOVERY HOUSE		87.9%	61.0% b	40.0%	12.0%
90 DAY OUTPATIENT		61.0% b	28.5%	37.0%	11.1%
PATH 4: LONG TERM RESIDENTIAL					
180 DAY EXTENDED CARE DRUG RESIDENTIAL	25.0%	100.0%	28.6%	25.0%	25.0%
90 DAY EXTENDED CARE RECOVERY HOUSE	15.0%	100.0%	88.8%	53.0%	8.0%
AND					
90 DAY RECOVERY HOUSE -- Alcohol		88.8%	70.2%	23.5% d	3.5%
OR					
90 DAY OUTPATIENT -- Alcohol		88.8%	70.2%	23.5% d	3.5%
PATH 5: MICA	10.0%				
30 DAY TREATMENT & DIAGNOSIS		100.0%	63.0%	37.0%	3.7%
90 DAY MICA TREATMENT		63.0%	55.8% c	46.0%	4.6%
AND					
60 DAY RECOVERY HOUSE		55.8% c	48.6%	8.5% d	0.9%
OR					
60 DAY OUTPATIENT		55.8% c	48.6%	8.5% d	0.9%
TOTAL	100.0%				100.0%

NOTES
a Derived from Table A6.8 b From Wickizer data c Interpolated d Split 50/50

The changes made in this example may be summarized as follows:

1) The percentage of offenders participating in the 90 day outpatient path was changed from 19% to 0%
2) Those participating in the 30/90 path were reduced from 29% to 20%
3) The 30/60/90 path was increased from 27.5% to 30%
4) Extended care drug residential treatment was increased the most, from 8% to 25%
5) Extended care (alcohol) residential was increased from 11% to 15%
6) MICA treatment was increased from 5.5% to 10%

As with previous examples, these ratios should not be construed as recommendations, but rather as examples to illustrate a point.

Note that by eliminating the 90 day outpatient treatment path and changing the others as noted above, the number of offenders who are in a residential treatment setting (at any given time) increases from 47 percent to 70 percent. Everyone spends at least 30 days in a residential program. Most spend at least 90 days. Twenty-five percent of the group (i.e. those in long term drug residential) spend the entire 180 days in a residential program.

The following table shows the new distribution of offenders by treatment modality using the assumptions outlined above.

TABLE 28

HYPOTHETICAL DISTRIBUTION OF OFFENDERS BY TREATMENT MODALITY

TREATMENT MODALITY	TOTAL	ROUNDED
90 DAY INTENSIVE OUTPATIENT	0.0%	0%
90 DAY REGULAR OUTPATIENT	30.1%	30%
30 DAY INPATIENT	12.3%	12%
60 DAY RECOVERY HOUSE	16.4%	16%
180 DAY EXTENDED CARE DRUG RESIDENTIAL	25.0%	25%
90 DAY EXTENDED CARE RECOVERY HOUSE	8.0%	8%
30 DAY TREATMENT & DIAGNOSIS	3.7%	4%
90 DAY MICA TREATMENT	4.6%	5%
TOTAL	100.0%	100%
RESIDENTIAL PROGRAMS	69.9%	70%
NON-RESIDENTIAL PROGRAMS	30.1%	30%

As shown in Section 8, this utilization data can be used to calculate the average reimbursement rate for offender treatment based on these new assumptions. Based on current reimbursement rates and the new distribution of utilization implied by these

assumptions, the average cost per person increases from $25 per day to about $33 per day. The derivation of this average cost is shown below.

TABLE 29

AVERAGE REIMBURSEMENT RATE CALCULATION
(Based on increased use of residential treatment)

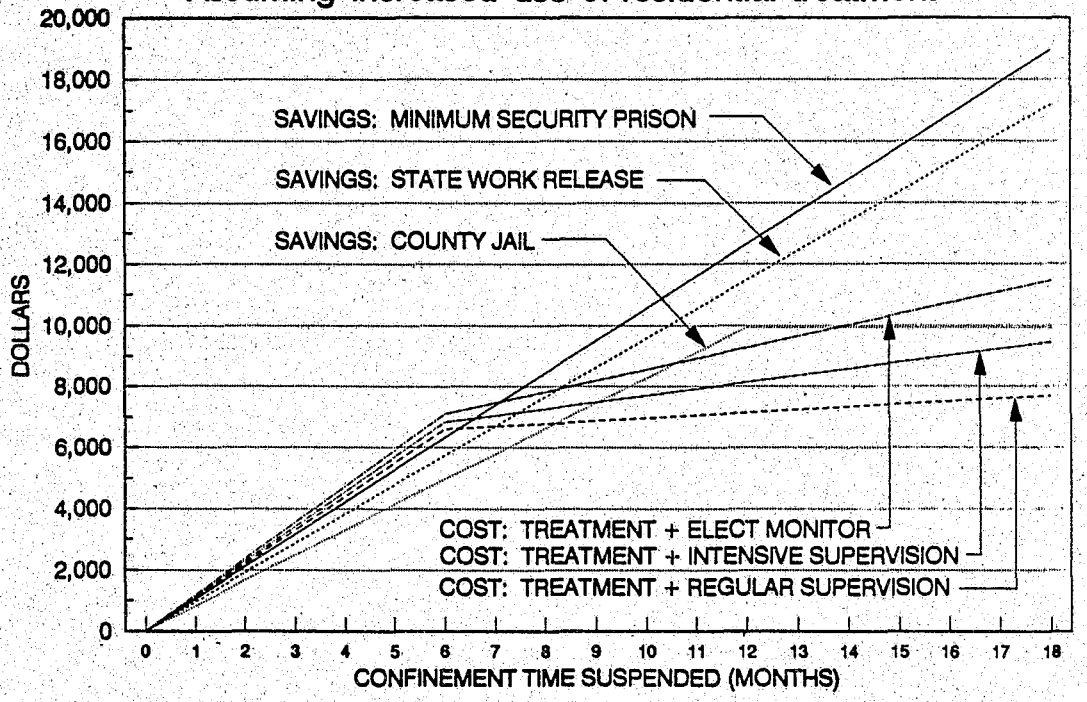
TREATMENT MODALITY	PERCENT OF TOTAL	DAILY RATE	PRODUCT
90 DAY INTENSIVE OUTPATIENT	0.0%	14.17	0.00
90 DAY REGULAR OUTPATIENT	30.0%	8.33	2.50
30 DAY INPATIENT	12.0%	52.94	6.35
60 DAY RECOVERY HOUSE	16.0%	30.25	4.84
180 DAY EXTENDED CARE DRUG RESIDENTIAL	25.0%	42.96	10.74
90 DAY EXTENDED CARE RECOVERY HOUSE	8.0%	24.97	2.00
30 DAY TREATMENT & DIAGNOSIS	4.0%	75.07	3.00
90 DAY MICA TREATMENT	5.0%	75.07	3.75
WEIGHTED AVERAGE			33.19

Using this higher average cost of treatment, the breakeven analysis was repeated. (See Table 30) As the chart illustrates, the breakeven points change for all options. Indeed, under this scenario, none of the alternatives breaks even with sentences of less than six months. Most require sentences of seven to eight months. Diversion from county jails makes financial sense only for those few jailed offenders who have sentences in the range of 9 to 12 months and who would be appropriate candidates for regular or intensive supervision.

When the effect of treatment failures at this higher cost of treatment was examined, again it was found that treatment failures do not appreciable change the financial implications of diversion from incarceration to treatment. The change in treatment cost itself has a large impact. Greater or fewer failures at any level of cost makes little difference. At this level of treatment cost, a change in treatment failure rates from 30 percent to 50 percent affected the breakeven point on most of the options. However, only in one case did the breakeven point shift by more than 15 days.

TABLE 30

BREAKEVEN ANALYSIS
Cost and Savings Per Person
Assuming increased use of residential treatment



The cost of treatment, shown in Table 31, is estimated at $33 per day for an average of 145 days of treatments in the community. If the offenders treated in 1996 were more often placed in residential treatment, then the added cost of that change would be another $16,500,000 above the cost of the current mix of treatment services.

TABLE 31

COSTS: MORE INTENSIVE TREATMENT
OFFENDERS WHO COULD ENTER TREATMENT IN 1996

TYPE OF PLACEMENT	OFFENDERS BY PLACEMENT	OFFENDERS NEEDING TREATMENT	OFFENDERS ENTERING TREATMENT	TOTAL TREATMENT COST
In local confinement	9,114	3,737 (41.0%)	1,868	$ 1,233,210
Under local supervision	53,519	5,138 (9.6%)	2,569	$12,292,665
In state confinement	13,183	5,405 (41.0%)	2,702	$ 1,783,650
Under state supervision	57,589	23,611 (41.0%)	11,806	$56,491,710
All PLACEMENTS	133,405	37,891 (28.1%)	18,945	$71,801,235

ANNOTATED BIBLIOGRAPHY

1992 Publications:

Kohlenberg, Elizabeth, Yette, Rebecca, and Mack, Curtis E; Needs Assessment Data Project Report: Division of Alcohol and Substance Abuse, FY 1990; Office of Research and Data Analysis, Planning Research and Development, Department of Social and Health Services, Olympia, WA, January 1992.

This study provides baseline information for planners to use to assess service needs and gaps. The following questions are addressed: how many people use DASA services in each area and what is the gender, age and ethnicity of these clients; how many clients are estimated for these service and how do these clients differ by age, gender and ethnicity; what was the actual cost of service received per client by area and how does this cost compare to the average cost of services for all clients.

Wickizer, Thomas, and Maynard, Charles; Analysis of Completion Rates of Clients Discharged from Drug and Alcohol Treatment Programs in Washington State; Division of Alcohol and Substance Abuse, Department of Social and Health Services, Olympia, WA, January 1992.

This study analyzes data procured through SAMS (Substance Abuse Management System). The study population included all clients (N: 6,559) discharged from treatment during fourth quarter 1990 in ten treatment modalities. The study determined client characteristics of the discharge population for each modality. Approximately 75% were between 20 and 40; roughly 75% were caucasian, 10% were black, and 10% were native American; 70% represented clients receiving treatment for alcohol related problems; 12% to 16% were for cocaine related problems. Treatment completion rates varied by modality: rates for intensive inpatient programs were 71% and for outpatient programs were 34%.

1991 Publications:

Baxter, Brent and Kleyn, Jeanne; Washington State's Second Offender Laws for Driving while Intoxicated: Results of Five Years of Evaluation; Alcohol and Drug Abuse Institute (ADAI), University of Washington, Seattle, WA, May 1991.
This report documents a five year study by ADAI for the Washington Traffic Safety Commission. The study's main focus was state compliance with federal and state mandates regarding repeat DWI offenders. The objectives of the study were to provide estimates of the number of persons arrested and convicted for DWI who had a prior DWI conviction within the previous five years and to assess the levels of court and jail compliance with federal and state guidelines for sentencing recidivist DWI offenders.

Based on ratios computed from two courts: Seattle District and Evergreen District, total estimated repeat offenders were 6,645 (1985), 5,918 (1986), 5,486 (1987), 4,325 (1988) and 6,968 (1989). for the same years 2,495, 2,837, 2,727, 1,956, and 3,172 offenders were convicted. Data from ten district courts were samples to estimate the sentencing and time served for repeat offenders. Recidivist DWI offenders who were sentenced to at least two days in jail and could clearly be shown to have served at least 48 consecutive hours were 38.4% over five years.

Harlow, Caroline Wolf; Drugs and Jail Inmates; 12 pp; U.S. Bureau of Justice Statistics, Washington, DC, 1991.

A report examines the effect of illegal drugs on the lives of persons accused or convicted of crimes. Data were derived primarily from responses to the U.S. Bureau of Justice Statistics' national surveys of local inmates in 1983 and 1989.

Money for illegal drugs was cited by 13% of convicted jail inmates as a reason they had committed their offense. Among inmates who had used drugs in the month before the offense for which they were convicted, 27% said they had committed the crime to get money for drugs. Nearly 1 in 3 robbers and burglars said they had committed their crimes to obtain money for drugs. More than one quarter of all convicted inmates said they were under the influence of drugs at the time of the crime. At least 4 of 10 convicted jail inmates said they were using drugs during the month before the crime; 1 of 4 said they were using cocaine or crack.

Inciardi, James A., McBride, Duane C.; Treatment Alternatives to Street Crime (TASC): History, experiences, and Issues; National Institute of Drug Abuse, 1991.

This report reviews 40 local TASC programs from 1972 through 1982, finding that the majority effectively linked criminal justice and treatment system, identified previously untreated drug-involved offenders, and intervened with clients to reduce drug abuse and criminal activity. From more recent examinations it appears the TASC initiative is meeting its operational goals. Most importantly, evaluation data indicate that TASC-referred clients remain longer in treatment than non-TASC clients, and have better post-treatment success.

Klocke, Karen A; "Drug-Related Crime and Addicted Offenders: A Proposed Response; Notre Dame Journal of Law, Ethics and Public Policy; 5(3), pp. 639-649, 1991.

The Substance Abuse Intervention Program, established in 1989 by the New York City Department of Correction (NYCDOC) has added new drug treatment services to the jails, specifically for cocaine users.

The NYCDOC's experience to date indicates several conclusions. Community based substance abuse treatment models, such as the therapeutic community, can be successfully adapted to correctional settings. Jail based treatment can help addicted inmates remain drug free during their incarceration. Drug treatment can reduce levels of violence and inmate rule infractions in jail. Treatment can help correctional systems save money on security staff. Effective discharge planning can increase the likelihood that an inmates will participate in long term community based substance abuse treatment on discharge.

Longhi, Dario; Oatis, Susan; Mudar, Karen; Spaeth, Dotty; Van Dyck, Michael; Shaklee, Margaret; Brown, Marsha and Hall-Milligan, Joan; The ADATSA Program: Clients, Services and Treatment Outcomes; Office of Research and Data Analysis, Planning Research and Development, Department of Social and Health Services, Olympia, WA, October 1991.

The study was sponsored by the Division of Alcohol and Substance Abuse to look at ADATSA clients and the ADATSA system. It describes the clients, evaluates the appropriateness of treatment placements, and identifies the major obstacles in implementing the program from the perspective of managers and directors of treatment agencies and assessment centers.

Client information was obtained from a sample (N: 1,118) assessed in the fall of 1989. Client employment, public assistance, and re-entry into DASA funded services were used as outcome measures. They cover a six month period after treatment completion or drop out.

Robins, Lee N. and Regier, Darrel A, eds; Psychiatric Disorders in America; The Free Press, New York, 1991.

This volume is based on a study (Epidemiologic Catchment Area) by the National Institute of Mental Health, which presents a comprehensive report on the prevalence rates of mental disorders in the United States. It uses a sample size of 20,000 people in five different areas, and represents the population with respect to age, sex, and racial/ethnic groups.

Type of disorders discussed include schizophrenic disorders, affective disorders, alcohol abuse and dependence, syndromes of drug abuse and dependence, panic and phobia, generalized anxiety disorder, obsessive compulsive disorder, somatization disorder, antisocial personality, and cognitive impairment. Chapters 6 and 7 on alcohol and drug disorders are of particular interest in this review.

1990 Publications:

American Jail Association; A Report of the Findings of a Survey of the Nation's Jails Regarding Jail Drug Treatment Programs; 25 pp.; U.S. Bureau of Justice Assistance, Washington, DC, 1990.

The 1987 Drug Treatment Program Survey is based on the responses of personnel at 1,737 jails in 48 U.S. states and the District of Columbia. Among the 1,687 jails that provided information, on 6.7% of the average daily inmate population of 192,461 were enrolled in drug treatment programs.

Even for facilities with programs, only 13% of inmates received treatment per day. Drug treatment services were more likely to be reported in larger jails; jails with a continuum of adjunctive support services (e.g., screening, urinalysis; and jails oriented toward developing inmate and staff (e.g., employee assistance) programs, as well as innovative approaches to inmate management (e.g., direct supervision). Even among many of the more comprehensive programs, treatment services were not comparable to those provided in a community residential or intensive outpatient program.

There is a need to develop a set of recommended standards to guide administrators and treatment staff in providing services. These standards might address such issues as staffing patterns and credentials, evaluation and quality assurance procedures, and staff training.

Anglin, M. Douglas; Hser, Yih-Ing; "Treatment of Drug Abuse"; Drugs and Crime, Michael Tonry and James Q. Wilson, editors, Crime and Justice Series, Volume 13, pp 393-460; University of Chicago Press, Chicago and London 1990.

A review assesses evidence of drug treatment effectiveness, particularly in relation to crime control.

The major drug treatment modalities: methadone maintenance, therapeutic communities, outpatient drug-free programs and criminal justice system based treatments such as civil commitment have all been shown to be successful by most outcome criteria. Programs with flexible policies, goals and philosophies produce better results than inflexible programs, especially when they adopt combinations of treatment components that are suited to individual clients' problems and needs.

The longer a patient remains in treatment, the more successful is the outcome; however, dropout rates are high for most modalities. Clients entering treatment under legal coercion do as well by most outcome criteria as volunteer clients, and they may stay in treatment longer.

The evidence on effectiveness suggests a social policy of expanded treatment capacities and options, as well as increased attention to adequate implementation of programs.

Beto, Dan Richard, and others; "Substance Abuse: Strategies for Community Corrections Agencies"; APPA Perspectives, 14(4), pp. 4-53, 1990.

A special issue of the journal presents strategies for use by community corrections agencies with substance abusing offenders. Dan Richard Beto provides a brief overview of the topic and introduces the articles that follow.

Carl G. Leukefeld commends the practice of coerced drug abuse treatment for offenders, and provides suggestions for how community corrections agencies might enhance their substance abuse services.

Mario Paparozzi critiques the "war of drugs", and urges caution in designing and operating drug intervention programs.

Lucia Meijer offers recommendations about substance abuse assessment procedures.

In a related article, Billy D. Haddock and Beto describe the efforts of a medium sized probation department to assess the drug and alcohol problems of offenders.

John J. Robinson and Arthur J. Lurigio discuss the relationship between institutional overcrowding and drug abuse, and describe treatment and supervision strategies used by the Cook County, IL (Chicago) Adult Probation Department.

Robert N. Levy and James E. Meyer describe the DIRECT (Drug Involvement Reversal through Education, Control, and Treatment) Program, an initiative of the Pima County, AZ (Tucson) Adult Probation Department that combines enhanced monitoring with drug treatment and education.

Clint Arnold and colleagues examine the development and operation of the Los Angeles County Probation Department's Narcotic Evaluator Unit, comprised of officers who specialize in working with substance abuse offenders.

Stephen A. Bocian reviews Maryland's Evaluation, Diagnosis and Referral Program, a cooperative effort by two state agencies to identify and assess substance abusing offenders and appropriate treatment referrals.

Gerald R. Wheeler and Amy S. Rudolph report on a study of the relationship between drug testing and recidivism.

Nancy Hadlock describes A Substance Abuse Program for Probationers, a project established by the San Diego Probation Department in 1989 whose components include assessments, intensive supervision, referrals, graduated sanctions and treatment initiatives.

Beth Weinman, Vernon Bowen and Joanie Abranson discuss a collaborative training effort of the American Probation and Parole Association and the National Association of State Alcohol and Drug Abuse Directors, Inc.

Gerstein, Dean R. and Harwood, Henrick J., eds; Treating Drug Problems: A Study of the Evolution, Effectiveness, adn Financing of Public and PRivate Drug Treatment Systems, Vol. 1, National Academy Press, Washington, DC, 1990.

The various charges of this volune discuss the history of ideas governing drug policy, the nature and extent of the need for treatment, the goals and effectivenes of treatment, the need for research on treatmetn methods and services, the costs of organization of the two-tiered national treatment system, the scope and organixing principles of public and private coverage, and recommendations tailored to each kind of coverage.

The report focuses on drug treatment, not alcohol treatment. Although the authors recognized that these problems overlapped, the Institute of Medicine has recently sponsored another study on alcohol treatment (Broadening the Base of Treatment for Alcohol Problems, National Academy Press, 1990)

Gerstein, Dean R., and Lewin, Lawrence S.;"Treating Drug Problems"; The New England Journal of Medicine, 9/20/90, pp. 884-848.

This article reviews a comprehensive report from the National Academy of Sciences' Institute of Medicine on drug treatment programs. It found a point prevalence of 5.5 million people who are dependent on or abusing drugs. The extent of ambivalence about entering or remaining in treatment was marked, mainly because treatment is demanding, inposes controls and demands hard work. People nearly always enter treatment under duress: either to manage personal problems or social problems. However, effectiveness of treatment is not impaired by the client's motivation.

Haynes, P.; "Sentenced to Get Better"; Drug Link, V 5, N 1 (January/February 1990), pp 8-10, 1990.

Whether or not treatment alternatives to custody for drug abusers can reduce prison populations are the subject of this article. Drug abusers who fail a strict court-imposed program are likely to be imprisoned as a sanction, but drug abusers are not always capable of complying with structured programs.

In England, there is a type of compulsory treatment for drug abusers in which many drug offenders are placed on probation with the condition that they reside in a specified therapeutic community. If the offenders abscond in the first few months of treatment, they will be rearrested and resentenced. This treatment approach works with a few offenders, but many abscond and end up in custody.

Further research is needed to compare the length of stay in rehabilitation for those on conditions of residence and those who are not. Also sentencing options already available should be better researched and developed.

May, Robert II, Peters, Roger H; Kearns, William D.; "The Extent of Drug Treatment Programs in Jails: A Summary Report"; American Jails 4(3), pp. 32-34, 1990.

A 1987 survey of 1,687 U.S. jails found that only about 7% of an average daily inmate population of 192,461 are enrolled in drug treatment programs. Even in jails having these programs, only 12,894 of 100,369 inmates (13%) receive daily treatment. Further, even among many of the more comprehensive programs, treatment services are not comparable to those provided in a community residential or intensive outpatient program. Only a small fraction, less than 10%, of those requiring drug treatment actually receive these services.

The costs of operating an in-jail drug treatment program are relatively modest. At an average program cost of $83,574 per year, comprehensive jail programs cost $3.50 per day, per inmate, above and beyond the ordinary cost of incarceration. The more desirable enhanced treatment services would raise this cost to no more than $8 per day.

There is a need to develop a set of recommended standards to guide administrators and treatment staff in provision of drug treatment services. In addition, technical assistance and consultation in staff training, treatment curriculum development, and assessment and evaluation are of critical importance.

(for a different evaluation of the same material, see the following)
American Jail Association; A Report of the Findings of a Survey of the Nation's Jails Regarding Jail Drug Treatment Programs, 25 pp., U. S. Bureau of Justice Assistance, 1990

Minnesota, Department of Human Services, Chemical Dependency Program Division; Drug Education Program for Minor Offenders: 1990 Evaluation; 87 pp; St Paul, MN: 1990.

A study evaluates Drug Overview and Encounter, a program established in Minnesota in 1976 in response to state legislation that reduced the crime of possession of 1.5 ounces or less of marijuana to a petty misdemeanor on the condition that the offender attend a special drug education program. The program was designed to address perceived informational and attitudinal deficits in young, minimal offenders. Data were collected from arrest records, and surveys of 612 judges and probation officers, and of 203 program participants.

Approximately 65-75% of the alcohol/drug offenders who participated in the program did not have repeat offenses during the two years following their attendance. Seven of the eight repeat offenses categorized as felonies resulted in prison sentences for participants. Some 98% of judges and probation officers believed the program was meeting the needs of clients "very well" or "okay". The main concern was the relatively high rate of recidivism (20-25%) for driving while intoxicated (DWI) clients who were referred to the program.

Recommendations include the following: (1) Continue the program as an effective and economical disposition for first-time offenders. (2) Study the relatively high rate of DWI recidivism among clients. (3) Increase funding to restore the original two evening class format, to increase promotional publicity and outreach, and to ensure provision of classrooms free from distractions of noise and other problems.

Read, Edward M., Daley, Dennis C.; Getting High and Doing Time: What's the Connection?; 80 pp; American Correctional Association, Laurel, MD, 1990.

This manual is intended to help offenders with drug or alcohol problems make the connection between their trouble with the law and their substance abuse. Topics include: understanding addiction; determining its severity; using Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and more formal treatment programs to aid in recovery; preventing relapse; working with parole and probation officers; and understanding the family's role. Case histories, suggested reading and self-help organizations are included.

Rua, Jim; Treatment Works: The Tragic Cost of Undervaluing Treatment in the Drug War; 30 pp.; National Association of State Alcohol and Drug Abuse Directors, Washington, DC, 1990

This report reviews 15 years worth of research findings on alcohol and drug abuse treatment outcomes.

In the Treatment Outcome Prospective Study (TOPS) findings showed the following. Less than 20 percent of clients in any modality were regular users of any drug, except marijuana, three to five years after treatment. Abstinence rates averaged about 40 to 50 percent, and improvements rates were 70 to 80 percent. The proportion of clients involved in predatory crimes was one-third to one-half of pretreatment levels in all modalities when examined three to five years after treatment. All modalities studies resulted in increased percentages of clients employed full time after treatment.

Both National Institute on Drug Abuse (NIDA) TOPS study and National Institute of Alcohol Abuse and Alcoholism (NIAAA) studies have shown that treatment is effective, and that effectiveness can be improved by matching patients to the most appropriate treatments available.

A study of California drug abuse services by Dr. Victor Tabbush found the benefit-cost ratio of drug treatment programs was $11.54: for every dollar spent for drug treatment service, $11.54 of social costs is saved.

NASADAD is particularly concerned about the underfunding of treatment services.
In 1988, total spending for alcohol and drug abuse treatment and prevention was about $2.1 billion. This amount is only 1% of the annual costs of drug abuse in the United States.

Swanson, R.M.; Florida Adult S.T.O.P. (Serious Targeted Offender Programs) Programs: Screening, Assessment, Treatment, Followup and Evaluation for Drug Involved Offenders, University of South California Law Center, Los Angeles, CA, 1990, 104 pp.

A report describes a proposed program for adult drug-dependent offenders whose criminality is causally linked with drug abuse. Designed to be responsive to Florida's STOP legislation, the program targets drug-dependent adult probationers in need of long-term, intensive treatment.

Phase I involves six months of intensive residential treatment in a modified therapeutic community located at a STOP institution. Phase II consists of three months of employment experience and transition work in a community residential reentry setting. Phase III provides nine months of supervised community outpatient treatment that decreases in intensity as the probationer responds to treatment and becomes established in the community.

Core treatment activities include: group counseling; relapse prevention; daily living skills; self-help groups; drug testing; AIDS education and prevention; drug education; and vocational training.

U.S. General Accounting Office; Drug Abuse: Research on Treatment may not Address Current Needs, Washington, DC, 1990, 40 pp.

A review of the current state of knowledge on drug abuse treatment finds that during the 1980s, while the nature of drug abuse in the U.S. fundamentally changed, knowledge on how to treat it advanced slowly. The relatively small research budget of the U.S. National Institute on Drug Abuse (NIDA) during most of that decade accounts in part for this slow progress. The lack of a strategic plan to direct research, and the lack of emphasis on the training of researchers, also slowed progress in understanding how to treat drug abuse.

Knowledge concerning treatment effectiveness is limited by the lack of recent large scale evaluations of treatment programs and methodological shortcomings of existing evaluations. Little is known about how

to match patients with the most appropriate treatment, the effectiveness of certain components of programs, and how best to treat individuals addicted to new drugs.

Despite the recent cocaine and crack epidemic, NIDA's treatment research program has given priority to developing therapies for addiction to heroin and other opiates. NIDA has recently begun to place additional emphasis on developing therapies for cocaine abuse, but results from this research are not expected for several years.

Vito, Gennaro F., Wilson, Deborah G., Keil, Thomas J.; "Drug Testing, Treatment, and Revocation: A Review of Program Findings"; Federal Probation, 54(3), pp. 37-43, 1990.

A study evaluates a drug testing/monitoring program for felony probationers and parolees in Jefferson County, KY. Data were gathered from 860 case files collected during 1988, the first year of the project. Clients who were tested and referred to the Kentucky Substance Abuse Program (KSAP) for treatment were divided into the following groups: those who completed the program (graduates) and those who did not (exits). A third group was tested, but not referred to KSAP (controls).

The program has been successful overall. Probation and parole officers used drug testing to identify clients for treatment and, if they continued to abuse drug, they were sent to prison. Only 3% of KSAP graduates were reincarcerated, compared to 17.5% of exits and 6% of controls. KSAP succeeds with a hard-core population who are most likely to abuse substances at a high rate. The information provided by drug testing, and the availability of effective treatment, offer valuable tools for probation and parole officers.

Wexler, H.K.; Falkin, G.P.; Lipton, D.S.; "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment"; Criminal Justice and Behavior, 17(1):71-92, 1990.

This study reports treatment findings for the Stay'N Out therapeutic community (TC), which has operated in the New York State corrections system for over 12 years.

Impediments to inmate treatment effectiveness are the generally non-therapeutic environment of prisons, the severity of inmate problems, and program inadequacies. The Stay'N Out program has largely overcome these obstacles.

This is the first large scale study (1,500) that provides convincing evidence that prison based TC treatment can produce significant reductions in recidivism rates for males and females.

The program reduced recidivism and the time spent in the program was positively related to increases in time until arrest for those who did recidivate. Maximum treatment benefit was achieved by clients in treatment 9 to 12 months. Clients who remained more than 12 months showed some reduction in treatment benefit.

(see the following articles by the same authors)
"Stay N'Out Therapeutic Community: Prison Treatment for Substance Abusers", Journal of Psychoactive Drugs, 1986, 18(3), 221-230.

"Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment: Preliminary Results", National Institute on Drug Abuse, 1985, presented at the American Society of Criminology annual meeting, San Diego, CA, November 1985.

see also)
Macdonald, D.G.; Follow-Up Study of a Sample of Participants in the Stay'N Out Drug Program, 12 pp, New York State Department of Correctional Services, Albany, NY 1987.

Willoughby, Deborah K.; The Wisconsin Drug Abuse Treatment Unit; 15 pp; U.S. Burear of Justice Assistance, Washington, D.C., 1990.

A manual describes the Drug Abuse Treatment Unit operated by the Wisconsin Department of Corrections, a comprehensive approach intended to reduce recidivism among hard-core felony offenders. The program combines the structure and principles of the therapeutic community drug treatment model with the methods of understanding altering the "criminal personality" developed by Dr. Samuel Yochelson and Dr. Stanton Samenow. Seventy-six percent of the 67 men who graduated from the program between 1982 and 1988 had not returned to prison in Wisconsin as of January 1989, compared to 41.5% of the general population of inmates.

Wish, Eric D., Gropper, Bernard A.; "Drug Testing by the Criminal Justice System: Methods, Research, and Applications", Drugs and Crime, Michael Tonry and James Q. Wilson, editors; Crime and Justice series, Volume 13, pp. 321-391; University of Chicago Press, Chicago and London, 1990.

A review examines drug testing of detainees and convicted offenders by the criminal justice system.

The purposes of drug testing are to screen for persons who have recently ingested a drug, to identify chronic drug users, to monitor and deter drug use, and to estimate national and local drug-use trends among criminals. Substantial research has examined the reliability and methodology of drug testing technologies.

Most criminal justice system tests involve urinalysis. Experimental research is underway on radioimmunoassay of hair samples. Much discussion of criminal justice system drug testing centers on pretrial testing, the U.S. National Drug Use Forecasting program, and the testing of juvenile detainees. Because adult offenders typically begin their drug use while young teenagers, drug testing of juveniles may provide the most effective place for early detection and prevention of drug abuse in a high risk population. Critical legal and ethical issues raised by testing individuals detained or monitored by the criminal justice system are discussed.

1989 Publications

Anglin, M.D., Brecht, M-L, Maddahian, E.; "Pretreatment Characteristics and Treatment Performance of Legally Coerced versus Voluntary Methadone Maintenance Admissions"; Criminology 27(3):537-557, 1989.

A study investigates whether heroin addicts coerced into methadone maintenance (MM) by actions of the criminal justice system differ from voluntary entrants in background characteristics, early risk factors, or drug use and criminal behavior. Interview data were obtained in 1978-1979 from 297 males admitted for the first time to three multiple-clinic county MM programs in Southern California from 1971 to 1973.

Those induced to enter the MM program through legal channels (51%) had slightly higher rates of serious property offenses and higher proportions of time incarcerated and under legal supervision, but they did not differ from voluntary entrants in overall criminal behavior during pretreatment periods.

All groups showed substantial improvement in level of narcotics use, criminal involvement and most other behaviors during treatment. Although there were similar levels of regression by all three groups in nearly all behaviors from treatment to posttreatment periods, these changes were significant only for property crime income, daily narcotics use and percentage of time in common law relationships. For other behaviors, despite a general pattern of regression toward pretreatment levels, the gains achieved were significantly sustained.

Bolton, K. and Watt, R.; "Motivating Change"; Drug Link, 4(4) 1989, pp 8-9.

This methadone maintenance program is designed to emphasize personal choice for heroin users. Treatment goals are negotiated with the client based on data and preference; controlled heroin use is a possible goal although not optimal for all. Motivation for change arises when the client views drug taking as incompatible with his or her self-concept.

Chaiken, Marcia R.; "In-Prison Programs for Drug-Involved Offenders"; 87 pp. National Institute of Justice, 87 pp, 1989, prepared by Abt and Associates.

The U.S. National Institute of Justice commissioned a survey of state departments of corrections to determine the current status of in-prison drug abuse programs. It also commissioned a review of evaluations to see whether any programs showed promise in post-release performance, particularly recidivism.

A report describes four of the programs that were chosen because, unlike the vast majority of prison programs, they collected information on subsequent behavior of inmates and reported relatively low (as low as 16%) recidivism rates. The programs are: Cornerstone Program in Oregon, Lantana Program in Florida, the Simon Fraser University Prison Education Program in British Columbia, and the Stay'N Out Program in New York.

The four programs share the following characteristics. Participants typically were heavily involved in drug use and committed many serious crimes before incarceration. The programs offer a comprehensive range of activities more typical of free-standing residential programs. Program staff are often drawn from non-correctional professions, are sensitive to security regulations and realistic about goals for participants. And, participants learn a range of practical life skills and come to feel they "own" the program.

Hubbard, R.L.; Marsden, M.E.; Rachal, J.V.; Harwood, H.J.; Cavanaugh, E.R.; and Ginsburg, H.M.; Drug Abuse Treatment: A National Study of Effectiveness; University of North Carolina Press; Chapel Hill, NC., 1989.

This book describes TOPS (Treatment Outcome Prospective Study): a multiyear study that involved more than 10,000 drug users who entered one of thirty-seven U.S. treatment programs in 1979, 1980, or 1981. The treatments involved methadone, residential and outpatient drug-free programs.

The book then describes client socio-demographic characteristics, the nature and severity of their drug abuse, and other client behaviors upon entering treatment.

Also discussed are the nature and extent of clients' drug abuse, and the types of behavior that interfere with productive lives before, during, and after treatment. Abstinence and improvement rates for each modality are presented.

Factors affecting post-treatment drug abuse and other behaviors such a criminal activity, employment, depressions, and alcohol use focus on the relationship between these outcomes and clients' pretreatment characteristics and treatment duration.

The costs and benefits of drug abuse treatment are considered in terms of its impact on crime reduction.

The evidence of this study shows that treatment of appropriate quality and duration does have positive results, both for drug abusers and for society, to the extent that treatment must be a major component of a national drug policy.

Lawson, Gary W. and Lawson, Ann W., Eds; Alcohol and Substance Abuse in Special Populations; 370 pp, Aspen Publishers, Inc., Rockville, MD, 1989.

This book examines special issues involved in the etiology, treatment, and prevention of alcoholism and other substance abuse among specific populations: women, individuals with mental health problems, the disabled, the elderly, blacks and Hispanics, physicians, adult children of alcoholics, adolescents, homosexuals, Native Americans, indigents on skid row, professional athletes, and the military. Within this format the physiological, psychological and sociological factors believed to play a role in casuing alcoholism or substance abuse are considered for each population.

Each chapter covers the following topics: a review of demographic information, substance abuse rates, and kinds of substances abused by the population under scrutiny. Authors of individual chapters generally have personal experience in working with the group discussed, and several are members of that specific population.

One consistent theme is that the family plays a major role in the etiology of substance abuse and thus, must be fully involved in treatment and prevention efforts.

Paugh, Pennell E., and others; "Substance Abuse: Responding to the Crisis"; Corrections Today, 51(3), pp 28-106, 1989.

A special section of this journal examines correctional system responses to substance abuse among U.S. inmates and probationers.

Pennell Paugh reviews findings shared by administrators from 47 states at a recent National Juvenile Substance Abuse Conference. Successful programs include Alcoholics Anonymous and Narcotics Anonymous, active recreational programs, and rapport and social skills instructions.

Gennero F. Vito evaluates the Kentucky Substance Abuse Program (KSAP), established in July 1986 to provide group counseling, urine testing, educational services and job placement to drug or alcohol-abusing probationers and parolees. Over a five year period, the KSAP had a significant effect on the reincarceration rates of participants.

Edward J. Latessa and Susan Goodman examine Sobriety Through Other People (STOP), an alcohol behavioral program begun in 1981 by the Lucas County (Toledo, OH) Adult Probation Department. STOP

participants must attend Alcoholics Anonymous, peer group and program coordinator meetings, and must submit to urinalysis. An evaluation conducted from 1984 to 1987 found that STOP participants were arrested and convicted less often than controls.

Bernadette Pelissier and Barbara Owen describe U.S. Bureau of Prisons (BOP) drug treatment programs, which include self-help groups, group psychotherapy, communication skills and personal development.

Gerald L. Vigdal and Donald W. Stadler evaluate the Wisconsin Division of Corrections' 1984 "impact on the market" approach , which successfully curbed drug use in correctional institutions by influencing the market. Kevin T. Smyley explores attempts by the New York City Department of Probation to initiate stricter supervision of the drug abusing probationer through the use of drug testing and other measures.

Edward M. Read provides a general overview of drug treatment, with emphasis on the self-help groups AA and NA.

Shaffer, H.J., Jones, S. B.; Quitting Cocaine: The Struggle Against Impulse; 198 pp, Lexington Books, D. C. Health & Co., Lexington, MA, 1989.

Based on oral interviews with cocaine addicts who quit their addiction without professional help, this book illustrates lessons for changing addictive behavior, raising new questions and ideas for clinicians seeking to improve drug treatment programs.

Quitting strategies and tactics often used by successful quitters are described, followed by an examination of how new quitters manage to prevent relapse.

A summary of the lessons from successful quitters outlines two stages: the emergency of addiction (initiation, activity produces positive consequences, and adverse consequences develop) and the evolution of quitting (turning points, active quitting begins, and relapse prevention). The lessons are applied to other aspects of drug treatment and prevention.

Vito, G.F.; "War on Drugs: The Kentucky Substance Abuse Program"; Corrections Today, 51(3), pp 34-36, 1989.

This article describes the Kentucky Substance Abuse Program, which provides group counseling sessions for substance abusing probationers and parolees in several regions of Kentucky. The evaluation tracked all persons referred from the program's beginning through March 1, 1988, using followup periods ranging from 6 to 20 months. The clients (209) referred and admitted to the program had the most severe substance abuse problems and showed the greatest risk of recidivism when compared to other clients on the probation and parole caseloads. After a six month followup period, none of the program graduates (47) had been reincarcerated for a personal crime. Under 10% of the program graduates were reincarcerated, compared to 36.6% of those who did not complete the program.

1988 Publications:

Anglin, M. D.; "Efficacy of Civil Commitment in Treating Narcotic Addiction"; Compulsory Treatment of Drug Abuse: Research and Clinical Practice, Carl G. Leukefeld and Frank M. Tims, eds., Monograph 86, pp 8-34; U.S. National Institute on Drug Abuse, Rockville, MD, 1988.

The California Civil Addict Program (CAP) was evaluated to determine whether compulsory treatment for narcotics addiction is effective. Eleven years of pre-admission data and 11 to 13 years of post-admission data were obtained during followup interviews. Findings showed that civil commitment and other legally coercive measures are useful and proven strategies to get people into a treatment program when they will not enter voluntarily.

However, the current shortage of treatment means that further coercion should not be implemented immediately. Funding for new programs or expansion of existing programs and outreach efforts to induce abusers to enter treatment voluntarily and at a lower cost than coerced entry are both needed.

A civil commitment program must include inpatient care as an option and close monitoring with regular urine testing of parolees in the community.

Anthony, L.M.; "Supervising the Chemically Dependent Person"; Federal Probation, 52(1) 1988, pp. 7-10.

Differential diagnosis is needed by the probation officer in supervising the chemically dependent person (CDP). Prospective clients must be screened to distinguish the historical user from the truly CDP, whose use results in dysfunctions in major life areas.

In screening, both qualitative and quantitative analyses are needed, and the intake, orientation, and assessment processes should be used to enhance evaluation. During intake and orientation the goals and conditions of supervision can be explained.

Assessment should include a review of the presentence record, a focused interview, review of institutional records, and a physical examination and medical history.

While not all clients require the same treatment of length of treatment, active intervention is essential with CDPs. The first step in intervention is to get the person invested in the treatment process.

Arbiter, N; "Drug Treatment in a Direct Supervision Jail: Pima County's Amity Jail Project", American Jails, 2(2) pp 35-36, 39-40, 1988.

The Amity Jail Project is a cooperative effort between the sheriff's department and a private drug treatment agency for inmates in a direct supervision jail. This project was funded by the Bureau of Justice Assistance in 1987 . It provides services for up to 50 inmates serving sentences over 45 days, and includes physical inspections, work teams, aftercare and referral system, and communication with probation officers and other criminal justice officials.
Because treatment success is strongly correlated with length of treatment, participants are strongly encouraged to continue treatment through AA, NA and Amity-on-the-street groups after release. The project highlights the utility of interdisciplinary approaches to the treatment of substance abuse and its associated recidivism.

Cook, L.F., Weinman, B. A.; "Treatment Alternatives to Street Crime"; Compulsory Treatment of Drug Abuse: Research and Clinical Practice, Carl G. Leukefeld and Frank M. Tims, editors; Monograph 86, pp 99-105; U.S. National Institute on Drug Abuse, Rockville, MD, 1988.

TASC programs, which began nearly 15 years ago, combine the influence of legal sanctions for probable or proven crimes with the appeal of a variety of innovative dispositions. TASC aims to interrupt

permanently the cycle of addiction, criminality, arrest, prosecution, conviction, incarceration, release, readdiction, criminality, and rearrest through treatment referral and closely supervised community reintegration.

The majority of the 40 local assessments of TASC programs have found the programs to be effective in reducing drug abuse and criminality, linking the criminal justice and treatment systems, and identifying previously untreated drug dependent offenders.

National evaluations have shown the TASC model to be a beneficial and cost-effective alternative to the criminal justice system for drug-abusing offenders.

Successful program elements include the establishment of broad support by the criminal justice and treatment systems, the use of appropriate eligibility criteria, and a comprehensive monitoring system.

Deschenes, E. P., Anglin, M. D., Speckart, G.; Differential Effectiveness of Legal Supervision on Narcotic Addict Behavior, 19 pp.; UCLA Drug Abuse Research Group, 1100 Glendon Ave., Los Angeles, CA 90024, 1988.

A study examines the effect of different intensities of legal supervision---defined as probation or parole, both with and without urine testing, and outpatient status (or intensive parole supervision) from the California Civil Addict Program---on the addition and criminal careers of narcotic addicts. Addicts admitted to methadone maintenance programs in Southern California between 1971 and 1973 were interviewed in 1978. Legal supervision with urine testing was the most effective alternative in reducing the percentage of time addicts spent on daily narcotics use and criminal behavior.

Edwards, Jose B.; "Assessing Treatability in Drug Offenders"; Behavioral Sciences & the Law; 6(1):139-148, 1988.

A study described the factors used by clinicians to assess treatability in offenders seeking statutory drug treatment benefits. Data were drawn from social histories , psychological reports, psychological test results and final staff letters of offenders (104) referred to an Ohio forensic center in 1976-1979.

The decision policy adhered to by the center was influenced primarily by nontechnical forms of information. Mental health professionals relied more on their judgments than on behavioral forms of information elicited during their clinical evaluations. The practitioners were allowed substantial discretion in selecting which non-technical information to use in distributing statutory benefits of drug treatment.

Golding, R.P.; "Treatment of Women with Drug Problems"; Women and the Penal System, pp 82-93; University of Cambridge Institute of Criminology, Cambridge, England, 1988.

The increasing number of drug addicted female inmates in English prisons is examined. The available evidence suggests that these inmates have certain unique problems because of their sex. A higher proportion are addicted to heroin rather than to other drugs, and women constitute the majority of benzodiazepine abusers in prisons.

Some 50 percent of addicted female inmates have been involved in prostitution to fund their habit. Further, the self-esteem of women with drug problems is notably low.

For drug addicted female offenders the possible benefit of treatment versus custodial sentence should be considered. When there is no alternative to incarceration, information on sources of help should be offered at the time of reception.

Gordon, Martin A., Jr., Lewis, David C.; "Drug Offenses and the Probation System: A 17 Year Followup of Probationer Status"; Federal Probation 52(2):17-27 1988; Washington, DC.

A 1987 study followed up 78 drug abusing probationers who had been supervised by a probation officer and aide at the East Boston (MA) Probation Department in September 1970. Data sources included probation records and interviews with probation officers and probationers.

Of the original group, 14.1% were deceased, and 18% had had constant problems with the law. Sixty-eight percent had varying degrees of success, with one-third essentially free of all criminal involvement. Younger probationers who used heroin and barbiturates were at greatest long-term risk and merited the longest probationary periods and most intensive supervision. Results suggest that a good probation officer with a manageable case load can have an impact on clients.

Haddock, Billy D., Beto, Dan Richard.; "Assessment of Drug and Alcohol Problems: A Probation Model"; Federal Probation 52(2):10-16, 1988, Washington, DC.

The Brazos County (TX) Adult Probation Department has developed an assessment model for substance abusing probationers that gives direction to probation supervision and guides therapeutic intervention.

The model facilitates a close and harmonious relationship between probation officers and therapists, aiding in the development of a supervision plan for the substance abusing offender. With regular monitoring and evaluation of the model by the department's administration, there is assurance of quality services and continuity of care, helping to document pre-treatment needs and post-treatment effects.

Harwood, H. J., Hubbard, R. L., Collins, J. J.; Rachal, J. V.; "Costs of Crime and the Benefits of Drug Abuse Treatment: A Cost Benefit Analysis Using TOPS Data"; Compulsory Treatment of Drug Abuse: Research and Clinical Practice, Carl G. Leukefeld and Frank M. Tims, editors, Monograph 86, pp 209-235; U.S. National Institute on Drug Abuse, Rockville, MD, 1988.

TOPS gathered longitudinal survey data on 11,000 drug abusers admitted to 41 treatment programs in 10 cities. The TOPS data were used to calculate victim costs, criminal justice costs, offenders' losses of productivity, costs to law abiding citizens. The analysis considers results only during the first year after discharge from treatment.

Results showed that greater lengths of stay in treatment produce real returns to society and to law abiding citizens. Findings showed greater economic returns from residential treatment than from methadone or outpatient drug-free treatment. Residential programs also appeared to have greater crime reduction benefits than did the other programs.

Hubbard, Robert L.; "The Criminal Justice Client in Drug Abuse Treatment"; Compulsory Treatment of Drug Abuse: Research and Clinical Practice, Carl G. Leukefeld and Frank M. Tims, eds., Monograph 86, pp 57-80; U.S. National Institute on Drug Abuse, Rockville, MD, 1988.

The Treatment Outcome Prospective Study (TOPS) is a large scale study of clients in 10 U.S. cities who entered 41 publicly funded outpatient methadone, residential and outpatient drug abuse treatment programs from 1979 to 1981. Self-report data were obtained on client drug use, criminal behavior and other behavior in the year before treatment, during treatment, and at 3 months or 1, 2, or 3-5 years after treatment.

The major program model used was the Treatment Alternatives to Street Crime (TASC) program. The analyses of intake data compared those referred to treatment through TASC programs (502), those involved with the criminal justice system, but not TASC at admission to treatment (855) and clients without any current involvement with either the system or TASC (1,078).

Criminal justice clients do as well or better than other clients in drug abuse treatment. TASC programs and other formal or informal criminal justice system mechanisms appear to refer individuals who had not previously been treated and many who were not yet heavily involved in drug use. This early interruption of criminal and drug-use careers may have important long term benefits in reducing crime and drug use among treated offenders. Criminal justice involvement also helps retain clients in treatment; the estimated 6 to 7 additional weeks of retention for TASC referrals provided more time for rehabilitation. There also were substantial changes in behavior during treatment for other criminal justice clients. These findings support efforts to continue and expand criminal justice programs such as TASC.

(no author listed); "Interview with AJA Special Projects Director"; American Jails, 2(3) pp 54-56, 1988.

Bob May, Director of Special Projects for the American Jail Association, discusses a demonstration project on drug treatment in jails.

The project will include model sites (one each in Arizona, Florida and Illinois) offering inmate drug treatment and the results of a survey of the nation's 3,300 jails to determine the number, costs, types, deficiencies, and effects of treatment programs. The project also includes quarterly site visits and the provision of technical assistance to jails wishing to implement drug treatment programs.

Grants are for 18 months although treatment periods vary among the sites, ranging from 30 days to 4 to 6 months. Programs range from weekly counseling session to full time residential treatment. All include referral to community-based treatment systems after release.

The effective of the programs will be evaluated in terms of continuation of post-release treatment, recidivism (including drug-related crimes), and urinalysis results at six months post-release.

Lipton, D.S., Wexler, H.K.; "Breaking the Drug-Crime Connection: Rehabilitation Projects Show Promise"; Corrections Today, 50(5), p. 144, 146, 155, 1988.

For each state Narcotic and Drug Research, Inc. (NDRI) helped analyze the scope of drug abuse and addiction among the inmate population, current treatment efforts and treatment capabilities, and state resources available for inmate drug treatment.

Guidelines were developed to aid states with treatment approaches that will reduce recidivism among serious drug using inmates. These suggest a focus on cocaine and heroin users, the use of urinalysis to identify drug abusers at arrest, intensive supervision of users, and compulsory participation in treatment programs for chronic cocaine and heroin users.

It is recommended that therapeutic community drug treatment programs be established in prisons, and that inmates who make good progress be paroled to residential drug free programs prior to completion of their sentences.

Program implementation, process, and outcome should be evaluated; and accountability/incentive systems should be devised for supervisors and line staff. Training, work opportunities, and job placement services should be offered to assist in the social rehabilitation of drug users.

Narc, D.N., Shaffer, J.W., Hanlon, T.E., Kinlock, T.W, Duszynski, K.R., Stephenson, P.; "Relationships between Client/Counselor Congruence and Treatment Outcome Among Narcotic Addicts"; Comprehensive Psychiatry, 29(1) 1988, pp. 48-54; National Institute on Drug Abuse, Rockville, MD.

This study used 897 narcotic addicts admitted to 25 drug treatment clinics in six states from July 1984 to June 1985. The clinics, located in Maryland, New Jersey, New York, Connecticut, Hawaii, and Washington, offered methadone maintenance, detoxification, abstinence, naltrexone treatment, and abstinence counseling. Different questionnaires were administered to both clients and counselors.

Blacks and Hispanics, particularly black females, generally showed the greatest association between congruence and outcome. White males showed the least congruence. Although the congruence/outcome relationships were slight, the need for tailoring treatment according to ethnic/sex classifications of addicts is suggested. Issues relating to the predictive utility of congruence as measure of treatment outcome are discussed.

Tongue, E, and others.; "Special Issue on Treatment, Rehabilitation, and Social Integration of Drug Dependent Persons"; Bulletin on Narcotics, 40(1):3-74, New York, 1988.

A special issue of the journal includes articles on the treatment, rehabilitation and social integration of drug abusers. Topics include: current approaches, techniques and programs; interventions to prevent the spread of AIDS through intravenous drug abuse; treatments incorporating the use of acupuncture, yoga, transcendental meditation, family therapy and school-based programs; characteristics of the population in a Spanish therapeutic community setting; and a report of post-treatment recidivism among Spanish heroin addicts.

(no authors noted); Treatment of Substance Abuse: Psychosocial Occupational Therapy Approaches, 80 pp; Haworth Press, New York, 1988.

Note: also published as Occupational Therapy in Mental Health, v.8, n.2 (1988)

Articles in this book provide insight into the role occupational therapy may play in substance abuse treatment, including behavioral and educational frames of reference as well as specific treatment modalities such as stress management, activities of daily living, and leisure counseling.

Approaches used by occupational therapists in alcohol rehabilitation programs are described, and an organizational framework for occupational therapy in alcoholism treatment is presented. An occupational therapy needs assessment tool for American Indian and Alaska native alcoholics is described.

Clinical issues related to the treatment of chemical dependency are also discussed, with consideration given to the desirability of abstinence from mood-altering drugs and the view of chemical dependence as a primary illness rather than an underlying symptom.

Uelman, G.F., and Haddox, V.G.; "Alternatives for Treatment"; Drug Abuse and the Law, pp. 11.1-11.76; Clark Boardman Company, Ltd., New York, 1988.

This chapter on alternatives for drug treatment discusses addition maintenance, therapeutic communities, and the decriminalization of marijuana and heroin.

In addiction maintenance the controlled medical prescription of heroin and methadone either to achieve gradual withdrawal from addiction or to maintain an addiction under medical supervision is discussed.

A review of the effectiveness of therapeutic communities in treating drug addiction notes the temporary success of such treatment while addicts remain in residence, followed by a high failure rate when they leave the treatment community.

The arguments for and against the decriminalization of marijuana have been more persuasive than those for the decriminalization of heroin as many states have softened the penalties for marijuana use. The effectiveness of the British heroin maintenance system is not necessarily an indication the United States would have the same success with its heroin addict population.

Uelman, G.F., and Haddox, V.G., "Sentencing the Drug Offender"; Drug Abuse and the Law, pp. 10.1-10.76; Clark Boardman Company, Ltd., New York, 1988.

This chapter examines the various sentencing alternatives available in drug cases: diversion, civil commitment for treatment, imprisonment, and probation.

Diversion for persons charged with drug use typically involves a treatment program and possibly indeterminate civil commitment. Innocent defendants may submit to diversion to avoid the risk or expense of a trial.

Should a defendant go to trial or plead guilty, the judge may use a number of sentencing options, including a prison sentence, a period of probation, a "split"sentence (jail followed by probation), or a fine.

Washington, Department of Corrections, Substance Abuse Treatment Program: Evaluation of Outcomes and Management Report, 17 pp; Washington State Department of Corrections, Division of Management and Budget, Planning and Research Section, 1988.

This analysis compared 693 program participants and 263 nonparticipants who were released by parole and sentence expiration between December 1983 and March 1984. The frequency of infractions was less after treatment than before. Although the frequency of substance use infractions was not significantly reduced after program participation, the frequency of other major infractions declined significantly. In addition, a significantly smaller proportion of the treatment participants returned to prison within two years of release.

The program monitoring system that has been recently implemented will enhance the efforts of the Department of Corrections to evaluate both the process and the outcomes of the program on an ongoing basis.

Washington State, Department of Corrections., Substance Abuse Treatment Program Evaluation, 70 pp; Olympia, WA, 1986.

A study of Washington State's inmate drug treatment program, begun in 1984, assesses the size of the target population and analyzes the process for providing drug treatment to prisoners.

The "in need" population was estimated by examining the records of a sample (265) of inmates released four months prior to the start of treatment services. Over 80% of the sample had drug abuse histories, indicating that about 2,000 inmates will need drug treatment annually. There was no relationship between substance abuse and offense of incarceration.

In the first year the 774 inmates who received treatment were screened with standardized assessment instruments prior to admission; 570 completed treatment, nearly four times the expected rate.

Wexler, H.K., Lipton, D.S., Johnson, B.D.; "Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody", 33 pp; Issues and Practices in Criminal Justice series; National Institute of Justice, Washington, DC. 1988.

Recent research provides ample evidence that offender populations are composed of large numbers of drug abusers and that drug-involved offenders commit substantial numbers of undetected crimes. But there is little evidence that criminal justice sanctions alone are as effective as drug treatment in reducing the drug use and criminality of cocaine-heroin abusers at liberty.

The experiences of effective programs indicate that the treatment method must have a sound theoretical and empirical basis for its implementation. The policy recommendations of this study focus on the identification of heroin and cocaine abusers at arrent, jail-based interventions, in-prison programs, and community treatment options.

Also included are system-wide recommendations pertaining to the organization and staffing of drug abuse treatment programs. A model for prison-based drug treatment is provided.

Wish, E.D.; "Identifying Drug-Abusing Criminals"; Compulsory Treatment of Drug Abuse: Research and Clinical Practice, Carl G. Leukefeld and Frank M. Tims, editors, Monograph 86, 139-159; National Institute on Drug Abuse, Rockville, MD 1988.

The main reasons for identifying drug abusing offenders are to identify active criminals, to identify persons in need of drug abuse treatment and other health care, and to monitor trends in community drug use. Identification methods include self-reports, review of criminal justice records, urinalysis tests, and hair analysis.

Urine testing is the most accurate method currently available for screening large numbers of offenders in criminal justice settings. However, tests only indicate probable use and must be followed by

confirmation of the amount of drug involvement, based on repeated testing, confrontation and interview, and information from records or reports.
Additional research on matching clients to effective interventions will be needed to make compulsory treatment a viable option for the criminal justice system.

1987 Publications:

Atmore, T, Bauchiero, E.J.; "Substance Abusers: Identification and Treatment"; Corrections Today, 49(7) pp 22, 24, 26, 110, 1987.

The Prerelease and Day Reporting Center of Hampden County, MA has developed a simply assessment model that parole or probation officers use to identify substance abusers. The use of the model rests on the view that substance abusers should not return to the community without efforts to deal with their alcohol or drug problems, because active users pose a threat to public safety.

The assessment process consists of an interview which initially focuses on factual data about the names of substances used, dates of first use and most recent use, usual amount and frequency of use, route of administration, and number of overdoses or blackouts. The second step is to focus on questions of self-perception, including problems caused by substance use and past involvement in treatment programs.

Programming for substance abusers includes individual counseling, group counseling, education, couples or family counseling, and participation in Alcoholics Anonymous or Narcotics Anonymous. Urine testing is included and is effective as a deterrent in this criminal population.

Drug Abuse in Florida: Summary of the Problem and Statewide Initiatives, 62 pp; Florida Department of Law Enforcement, Tallahassee, FL 1987

Based on a 1987 survey of 228 local law enforcement agencies and 45 major detention facilities, it was found that drug abuse is a major problem in the state, accounting for significant economic losses, fatalities, and 65% of all arrests.

Fifty-six percent of the inmate population admit to narcotics use, and 55 percent are incarcerated for narcotic-related offenses in the local detention facilities.

Treatment and rehabilitation programs have been established in state and local detention facilities. These include assessment, inpatient and outpatient treatment, counseling, training, education, recreation, and aftercare services.

"Drug Enforcement and Prevention Strategy"; Prosecutors Perspective, 1(2) complete issue, 20 pp, 1987; American Prosecutors Research Institute, Alexandria, VA.

These summaries of research studies are designed to provide an overview of issues related to drug law enforcement and the effectiveness of treatment programs for drug abusing offenders.

Issues include the effectiveness of drug testing, whether drug use is a mitigating or aggravating factor in criminality, methods for improving the identification of drug abusers, strategies for reducing crime by probationers, and the role of the district attorney at the pretrial stage.

Individual papers examine the association between heavy marijuana use and crime among detained youth, the role of compulsory treatment for drug and alcohol abusers, and the effectiveness of a prison therapeutic community for substance abuse treatment.

Faupel, C.E., Klockars, C.B.; "Drugs-Crime Connections: Elaborations from the Life Histories of Hard-Core Heroin Addicts"; Social Problems, 34(1): 54-68, 1987

There are two key hypotheses about the causal relationship between heroin addiction and criminality: 1) Heroin addiction promotes criminal activity by placing a heavy financial burden on the addict which cannot normally be met through legal means; and 2) Connections in the criminal subculture which distribute heroin facilitate and encourage criminal solutions to the problem of financing heroin addiction.

Life history interviews with 32 heroin addicts suggest that both hypotheses are true for only certain periods in addict careers, but the causal dynamics are neutralized or reversed at other periods. These findings suggest some specific refinements and alterations in treatment and enforcement strategies and complicate current theoretical speculations and empirical findings on the drugs-crime connection.

Mirin, S.M. and Poster, Elizabeth, eds; "Current Research in Substance Abuse and Alcoholism"; Current Research in Private Psychiatric Hospitals, pp 24-37, 1987.

This study reviews the general research on the psychopathology of substance abusers and alcoholics, followed by summaries of research on specific psychopathologies of opiate addicts, stimulant abusers, and CHS depressant abusers. Research on familial factors; treatment and followup; and pharmacologic approaches to treatment are discussed.

Drugs and Crime, Phase Two: A Study of Individuals Seeking Drug Treatment; 83 pp; New South Wales Bureau of Crime Statistics and Research, Sydney, Australia, 1987.

Interviews were conducted with 134 individuals at eight drug treatment agencies in the Sydney metropolitan area in 1985. Heroin was the drug most used by respondents (94.8%), and/or the drug for which they were seeking treatment. Prior to treatment, 64% reported selling drugs daily or frequently, usually to people they knew or who had been referred to them.

When asked about their historical involvement in crime, respondents reported being mostly involved in drug selling (33%), break/enter and steal (30.7%), and fraud (22.8%). More respondents had sold drugs, stolen a car, or shoplifted prior to or simultaneously with their first use of heroin than after; while for other crimes, the first offense was more likely to have occurred after the first use.

In most instances, regular involvement in drug selling occurred before the onset of regular heroin use while the opposite was true for regular involvement in property crime.

Stitzer, M.L., McCaul, M.E.; "Criminal Justice Interventions with Drug and Alcohol Abusers: The Role of Compulsory Treatment"; Behavioral Approaches to Crime and Delinquency: A Handbook of Applications, Research, and Concepts, Edward K. Morris and Curtis J. Braukmann, eds., p 331-361; Plenum Press, New York 1987.

This chapter examines the relationship between substance abuse and crime from the perspective of behaviorism and discusses several intervention strategies that can be used with criminally involved substance abusers, including incarceration, community supervision, and compulsory treatment.

In reviewing the criminal justice system's intervention with drug and alcohol abusers, the following forms of intervention are noted: restricting supply, incarceration, community supervision, methadone maintenance treatment, compulsory drug abuse treatment programs, voluntary or compulsory residence in substance free therapeutic communities and compulsory alcoholism treatment. The authors report evaluations of the compulsory treatment approaches concluding they are not always effective.

The variables that appear to influence the outcome of treatment for substance abusers include: treatment efficacy, client characteristics, contingencies maintaining treatment and participation, and concurrent legal sanctions.

1986 Publications:

Baldwin R.; "Policy on the Use of Methadone Maintenance"; Exploring the Alcohol and Drug Crime Link - Society's Response, R. A. Bush, ed., pp 241-248, 1986.

A review of relevant research in Australia and other countries indicates there is sufficient evidence to establish that male heroin addicts' incidences of arrest for violent and property crime diminish significantly when they receive methadone maintenance.

A policy currently under consideration in New South Wales would introduce centralized assessment for methadone maintenance and an improved geographical distribution of programs in the regions where it is used, which would permit an improved systematic method of data collection on the programs and their effectiveness.

Biven A., Benton, D.; "Therapeutic Community Alternative"; Exploring the Alcohol and Drug Crime Link - Society's Response, R. A. Bush, ed., pp 93-102, 1986.

This paper describes the drug treatment program of the Buttery Therapeutic Community in New South Wales, and suggests how its principles can be applied to inmate drug treatment programs.

Stage one teaches residents about addiction and leads them to face their own addictions, its consequences for their lives, and the possibility of change. Stage two guides residents in an analysis of old patterns of thinking, feeling, and behaving that related or led to their drug abuse. Stage three involves the residents assuming more responsibility in the Buttery Community while maintaining personal responsibility for managing thoughts, feelings, and actions. Stage 4 extends responsibility to living in the community.

The application of theses stages in a prison requires assessment and detoxification facilities, drug and alcohol education groups, self-help groups and access to drug and alcohol counselors, and therapeutic communities within the prison system.

Contact Center, Inc.; "Drug Testing"; Corrections Compendium, Lincoln NE, 11(2):12-13, 1986.

A national survey reports on drug testing of offenders in U.S. correctional institutions, probation and parole. Ninety-two percent of respondents, representing the U.S. Federal Bureau of Prisons and 47 states, report use of drug testing. Tests are taken at intake/classification in 11 systems and upon reasonable suspicion in 41. Test results are used in disciplinary hearings in 83% of the states. Half the corrections systems report at least one law suit resulting from drug tests.

Thirty-three of 37 reporting state probation agencies test probationers. Twenty-six states test those whose offense is alcohol or drug related; Idaho and Mississippi test all probationers. Twenty-nine states randomly test probationers. Thirty probation systems use these test results in revocation hearings.

Forty-four of 48 surveys parole systems use drug testing. Parolees with a history of alcohol or drug abuse are most frequently tested, usually under conditions of reasonable suspicion. All parole systems, except Delaware, use results in revocation hearings.

Carter-Goble Associates, Inc, Birch and Davis Associates, Inc.; Correctional Treatment Facility for the District of Columbia: A Summary Report, 48 pp; National Criminal Justice Reference Service, Rockville, MD 1986

Inmate data and criminal justice system statistics for 1975-1985 in the District of Columbia were used to examine the need for and feasibility of a treatment program for inmates with a history of substance abuse. Results showed that 85 percent had histories of previous substance abuse, and 91 percent had been previously incarcerated.

Consequently, a major treatment center is proposed to provide evaluation of inmates on entry into the system and treatment for abusers and special needs inmates. The proposed facility will house reception and diagnostic, substance abuse, and mental health programs. A 64 bed infirmary; a 16 bed behavioral unit; and an 800 bed unit for intensive residential treatment are included in the facility. The total program also will provide prerelease and after care components.

Capitol costs are estimated at 70.5 million for construction, and 23.5 million for annual operational expenses.

(no author listed); Maine County Jails: A Survey of the Substance Abuse Treatment Needs of Inmates; Maine Alcohol and Drug Abuse Planning Committee, Augusta ME 1986.

Telephone interviews were conducted with representatives of 11 jails providing substance abuse services without state funds.
All respondents expressed a need for additional services although two wanted to try the program prior to making a final commitments. All programs surveyed were inadequate in terms of professions services: only five jails had professional in-house substance abuse services, and service availability varied from 1.5 to 20 hours per week.

Only one jail had a formal presentencing or post-incarceration substance abuse program although many jails refereed releasees to community substance abuse programs on a regular basis. Services, if implemented, should be purchased from local providers to permit flexibility and to accommodate the need for diversity.

Miller, Brenda A., Welte, John W.; "Comparisons of Incarcerated Offenders According to Use of Alcohol and/or Drugs Prior to Offense"; Criminal Justice and Behavior, Newbury CA, 13(4): 366-392, 1986

Using data from the U.S. Bureau of Justice Statistics' 1981 and 1983 surveys of state prison inmates and 1978 survey of jail inmates, a study compares incarcerated and sentenced offenders (14,341) who used drugs only, alcohol only, both drugs and alcohol, and neither drugs nor alcohol prior to their offense.

Alcohol and/or drugs use prior to the offense was reported by 60% of the offenders. Among those who used psychoactive substances prior to their offense, alcohol use only was the most common pattern (30.5%), followed by alcohol and drugs (16.4%), and drugs only (13.8%). The group using alcohol and drugs prior to the offense represents young offenders extensively involved in such substance use, exceeding all other groups. This may signify a trend toward more psychoactive substance use.

Visser, P.; Alcohol and Drug Education - A Correctional Perspective in South Australia; Exploring the Alcohol and Drug Crime Link - Society's Response, R. A. Bush, ed., pp 129-140, 1986

This paper reviews the history of drug and alcohol treatment programs in South Australia's correctional facilities, and describes plans for the introduction of education programs for offenders sentenced to community service in South Australia.

Under South Australia's Offenders Probation Act, community service includes the condition that the offender attend a course of instruction for two hours a week as arranged by the corrections department. The department is planning a range of courses suitable for offender needs and interests, which will include drug and alcohol education. The initial course will be a low-key approach designed to help offenders identify any abuse problems in their own lives. By creating an awareness of the effects of alcohol or drug abuse, the course may prevent nonabusers from becoming abusers, constrain moderate abusers from becoming serious abusers to seek treatment.

1985 Publications:

Cancrini, L.; Costantini, D.; and Mazzoni, S.; "Drug Addiction Among Young People: A Study of Typology and Its Relevance to Treatment Programmes"; Bulletin on Narcotics, 37(2-3) 1985, pp. 125-133

This study classifies drug addition, on the basis of clinical observation, into four types: traumatic, actual, transitional, and sociopathic.

Traumatic addiction follows a trauma, generally with an abrupt and acute onset. Actual addition involves an active conflict in a youth's social environment that produces feelings of uneasiness and other disturbing factors. Transitional addiction is characterized by various psychological disorders that accompany the onset of drug addiction. Sociopathic addiction involves a psychosocial conflict expressed in "acting out" behavior and a number of personality disorders.

This classification helps in making an appropriate selection of a treatment method and in the evaluation of a treatment program.

Traumatic and actual types of addiction have a more favorable prognosis. Individual psychotherapy and support in a medical setting is effective for the traumatic type addiction; treatment in a family setting appears to be suitable for both actual and transitional types of additions. The therapeutic community may prove to be effective in the treatment of persons affected by sociopathic addition.

Glatt, M; "Wormwood Scrubs Annexe - Reflections on the Working and Functioning of an Addicts' Therapeutic Community within a Prison"; Prison Medicine, Sarah Cawthra and Catherine Ginty, eds., pp 83-98, Prison Reform Trust, London, 1985.

The Wormwood Scrubs Annexe has 40 prisoners, half of whom are addicts. The program provides inmates with the chance to reform both their addictions and their aggressive tendencies. It provides a humane, hopeful atmosphere that contrasts with that of traditional prisons. Although a high proportion of the inmates have histories of violence, violence is almost nonexistent in the Annexe.

The program's lack of effect on reconviction rates may result from its lack of aftercare services. But inmates, staff, and observers believe that the work and the methods of the Annexe should become part of other components of the British prison system.

Lettieri, Dan J., Sayers, Mollie A., Nelson, Jack E, eds; National Institute on ALcohol Abuse adn Alcoholism Treatment Handbook Series, No 1: Summaries of Alcoholism Treatment Assessment Research; U.S.Departmetn of Health and Human Services, (85-1379), National Institute on Alcohhol Abuse and Alcoholism, Rockville, MD, 1985.

This volume is a resource and reference handbook for researchers in the alcoholism treatment field. It provides highlights of current work and thinking in this field with emphasis on outcome studies of major importance, longitudinal studies, empirical studies matching clients with treatment approaches, evaluations of specific methodological approaches, and studies identifying and defining relevant assessment variables.

It highlights materials published from 1976 through 1984.

Lightfoot, L., Kalin, R., Laverty, S.G., MacLean, A., Darke, J. Hodgins, D.C.; Ontario Region Offender Alcohol Drug Treatment Development Project, Phase II, Final Report, 169 pp; Correctional Consultation Centre, Canada, 1985.

This report describes the methodology and findings of the treatment needs analysis (Phase II) of Canada's Federal Offender Alcohol and Drug Treatment Development Project, which involves the development of a regional plan for the creation and implementation of treatment services of substance abusing offenders.

Phase II, which involved a 1984-1985 assessment of inmate needs for drug treatment programs, included semistructured interviews with 59 staff from nine Ontario regional institutions and personal structured interviews with 275 inmate volunteers.

Four types of substance abusers were identified: alcohol abusers (37%), young drug abusers (15%), young polydrug and alcohol abusers (28%), and psychiatrically impaired abusers (22%). The data indicate a need for a variety of treatment options to meet the needs of these subgroups.

The proposed treatment management system consists of case identification, assessment, referral to treatment, short-term evaluation, institutional monitoring, prerelease assessment, community aftercare, and followup that includes long term evaluation.

Mabli, J., Nesbitt, K.L., Glick, S., Tilbrook, J., Coldwell, B.; "FCI (Federal Correctional Institution) Fort Worth Substance Abuse Evaluation - A Pilot Study"; Federal Probation, 44(3) 40-45, 1985.

Attitude and Risk Scale questionnaires were completed by 113 inmates participating in a drug rehabilitation program at the Federal Correction Institution in Forth Worth, TX. Behavioral data were collected to evaluate the program's effects on attitudes toward drugs and adjustment to incarceration. The program uses a holistic approach including cognitive restructuring through counseling, stress management, Narcotics Anonymous, self-awareness, and relaxation therapy.

Analysis of post-test data for the 47 inmates who completed the six month program indicates decreased depression and fatigue levels and maintenance of above-average positive mood levels. Perceived riskiness of regular drug use declined, especially with respect to attitudes toward cocaine, LSD, and amphetamine use. Perceived dangerousness of barbiturate use increased.

Recommendations for future evaluations of inmate drug rehabilitation programs are made.

Treatment Alternatives to Street Crime (TASC); Philadelphia Crime Commission, Philadelphia, PA; National Criminal Justice Reference Service, Rockville, MD 1985.

TASC identifies substance abusing offenders, refers them to community treatment resources, and monitors the offenders' treatment. The program aims to decrease the burden on criminal justice agencies caused by alcohol and drug dependent offenders and recidivists. Critical program elements include planning, development of eligibility criteria, establishment of assessment and referral mechanisms and monitoring of participants' progress. Program implementation involves an assessment of need for the program, a survey of available community treatment resources, and support building.

Results have included a reduction of alcohol and drug medical crises in jails and a reduction in recidivism among treated offenders.

Vaglum, P.; "Why Did They Leave the Drug Scene? A Followup Study of 100 Drug Abusers Treated in a Therapeutic Community Ware"; Journal of Drug Issues, Summer 1985, pp 347-355.

This study examines outcomes for 100 juvenile and young adult Norwegian drug users followed up 4 to 5 years after drug treatment in a therapeutic community ward between 1967 and 1974.

Forty-four percent were completely abstinent from drugs in the prior year. Compared to the nonabstinent group, abstinent subjects showed milder drug abuse at admittance to treatment, were more rarely involved in criminal activities, were alloplastic or had reality testing deficits, and more often perceived their families as divided.

During therapy, they more frequently relinquished membership in the drug culture, and more often improved their educational and/or occupational competence and relationships with parents.

At followup they attributed their abstinence to both individual and situational factors including a conscious decision to abstain, having a future, feeling worthy, and establishing new relationships, particularly with a spouse or fiance.

Collins, J.J., Hubbard, R.L., Rachal, J.V., Cavanaugh, E.R., Craddock, S.G., Kristiansen, P.L.; Criminality in a Drug Treatment Sample - Measurement Issues and Initial Findings, 101 pp; Research Triangle Institute, Research Triangle Park, NC, 1982.

This report addresses criminality indicators developed from Treatment Outcome Prospective Study (TOPS) data, a large multiscale study of clients in federally funded drug treatment programs from 1979 to 1981.

The TOPS research collected data on arrests, self-reported offenses, convictions, incarcerations, and illegal income from respondents in pre-treatment, in treatment, and post-treatment periods.

A comparative analysis of self-reports of arrest with official records suggested TOPS self-report data were fairly accurate and complete. The report reviews the TOPS methodology and selected findings regarding participants' criminal behavior and involvement with the criminal justice system, noting that these clients were much more likely than the general population to report criminal behavior and contacts with the police and courts.

A literature review emphasizes research dealing with the drug-crime relationship or the effects of drug treatment on criminal behavior. Research and policy implications of the report's findings are discussed.