Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community

Prepared for:

Office of National Drug Control Policy
Treatment and Criminal Justice System Conference

February 20, 1998

Prepared by:

Faye S. Taxman, Ph.D.
Associate Research Professor
Coordinator, Treatment and Criminal Justice Supervision
W/B High Intensity Drug Trafficking Area (W/B HIDTA)
University of Maryland, College Park
7500 Greenway Center Drive, Suite 900
Greenbelt, Maryland 20770
301-489-1700.

The Washington Baltimore High Intensity Drug Trafficking Area (HIDTA) project is funded by the Office of National Drug Control Policy under grant number I7PWBP528 Special thanks are given to the administrators and staff from the participating agencies as well as the W/B HIDTA including Mr. Stephan Sherman, Mr. Dennis McCarthy, Ms. Christine Depies, Mr. Bruce Kubu, and Mr. Tom Carr for their assistance in this project. Dr. Dorothy Lockwood also contributed to this paper. Special appreciation is given to Ms. Nancy Ford and Mr. James Mora for their assistance in preparing this paper. Points of view in this document are those of the author and do not necessarily represent the official position of any agency. Any questions can be forwarded to the author at 301-489-1705 or ftaxman@bss2.umd.edu.

Reducing Recidivism Through A Seamless System of Care: Components of Effective Treatment, Supervision, and Transition Services in the Community

Over five million adults in the United States are under the control of the criminal justice system, either in prison, jail, probation, or parole. These five million Americans account for 50 to 60 percent of the cocaine and heroin consumed in the United States. Addressing the demand for drugs among this population is synonymous with addressing the drug problem in this country—by targeting the addiction problem of the majority of known consumers of drugs, we impact the marketplaces for selling drugs, the associated crime and violence, and improve the quality of life for many communities. The involvement of the criminal justice system is an added bonus because coerced models of treatment engage offenders in behavior changing interventions and settings, control drug use and criminal behavior, and change drug consumption habits.

Coerced models of treatment for the offender population, although frequently discussed, have not been implemented within the larger domain of the criminal justice system. The tendency is to implement programs to serve smaller populations rather than the masses of offenders that need treatment interventions. Less than 15 percent of the offender population receive some type of treatment services, although the majority of the services are self-help groups and drug/alcohol abuse education (CASA, 1998; Peters, et al., 1992). The attractiveness of program concepts such as boot camps, drug courts, jail and prison based treatment, day reporting programs, and others continues the tradition of trying to deliver treatment services to a small percentage of offenders. The focus on programs, instead of systemic policies and practices, negates efforts to provide widespread and effective treatment services in all domains of correctional control (e.g., jail,

prison, parole, and probation). It reduces even more the likelihood that offenders will receive services as they move through the criminal justice system.

The vast number of studies on drug treatment over the last 20 years has clearly demonstrated that drug treatment is a powerful tool in the "war on drugs" in *all* correctional settings. The effectiveness is enhanced when offenders are provided treatment in jail/prison, balanced by continued treatment in the community (Lipton, 1995; Taxman and Spinner, 1997). In order to have an impact on the drug problem, drug treatment must be offered as a general practice instead of on an isolated basis. Research has identified the components of effective treatment programs that reduce drug use and criminal behavior. These research studies illustrate how treatment services, in conjunction with drug testing, supervision, and immediate consequences (sanctions), are critical components of an effective treatment delivery system.

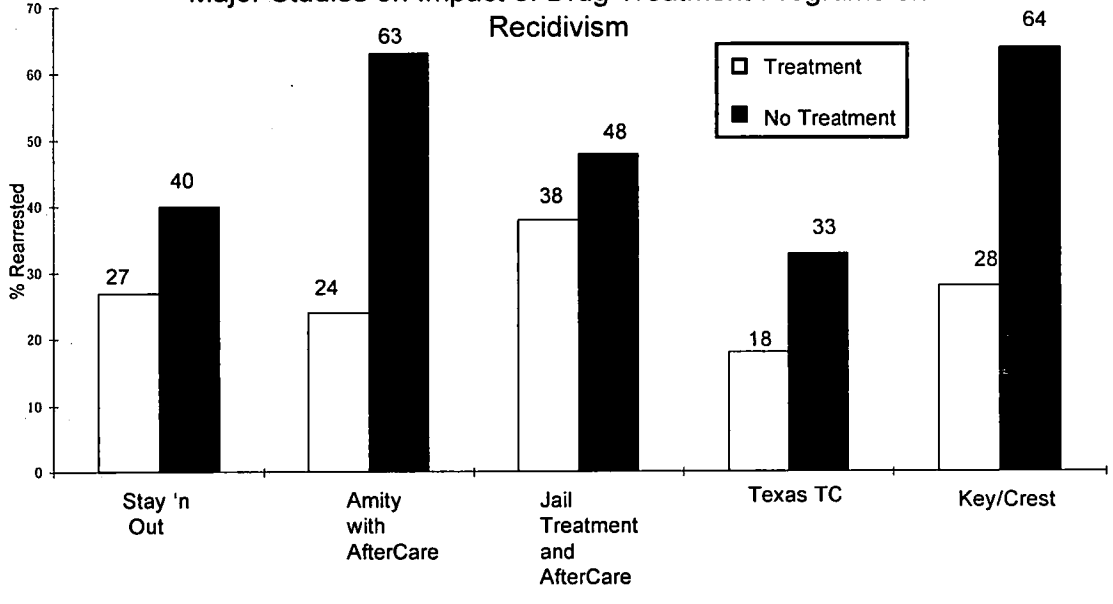
This paper presents a systemic case management model of substance abuse treatment, testing, and sanctions for offenders implemented as part of the Washington/Baltimore High Intensity Drug Trafficking Area (W/B HIDTA) project sponsored by the Office of National Drug Control Policy (ONDCP). The focus of this effort is to reduce recidivism and drug consumption among hard-core users of drugs, or offenders. This paper has four purposes: 1) to provide an overview of treatment as a crime control measure; 2) to present the typical barriers to offenders receiving treatment; 3) to identify core components of the W/B HIDTA seamless system of care, particularly for transition services; and 4) to identify the core principles of successful treatment and transition interventions.

Treatment As A Crime Control Tool

A growing body of empirical studies illustrates the impact of drug treatment services on offender criminal behavior and drug use. These studies continue to demonstrate that drug

treatment is a viable tool to address the drug consumption and criminal behavior habits of offenders. The studies, as shown in Exhibit 1, show that offenders participating in drug treatment services are less likely to be rearrested or return to jail/prison than similar offenders who are not participating in drug treatment services. The importance of these findings is the consistency across treatment programs offered in the community, in prison, or in jail. As noted by Duffee and Carlson, "drug treatment programs are so cost effective that the money saved on crimes not committed *just while offenders are in treatment* is sufficient to offset the costs of treatment" (1996:585). Drug offenders, when offered drug treatment services, have better outcomes.

Exhibit 1:
Major Studies on Impact of Drug Treatment Programs on Recidivism



Source: Simpson, 1997; Taxman and Spinner, 1997.

The good news about drug treatment is that drug offenders, when offered drug treatment services, have better outcomes than offenders who do not participate in the programs. Drug treatment services both reduce the incidence of criminal behavior and increase the overall length of crime-free time for offenders. Exhibit 2 illustrates this impact in a study of offenders that participated in a jail-based treatment program that included a continuum of care. Of the offenders

participating in the jail drug treatment program, 38.5 percent were rearrested within 24 months after release from jail compared to 48.7 percent of the comparison group. The average offender participating in jail and community treatment took an average of 282 days to be rearrest compared to 201 for the comparison group, or an 81 day difference (Taxman and Spinner, 1997). Treatment has the added benefit of slowing the spread of AIDS, increasing employment opportunities, and reducing societal costs of addressing abhorrent criminal behavior and substance abuse.

Exhibit 2:
Impact of Jail Treatment, Community Treatment, and
No Treatment on Recidivism (24 Months Follow-up)

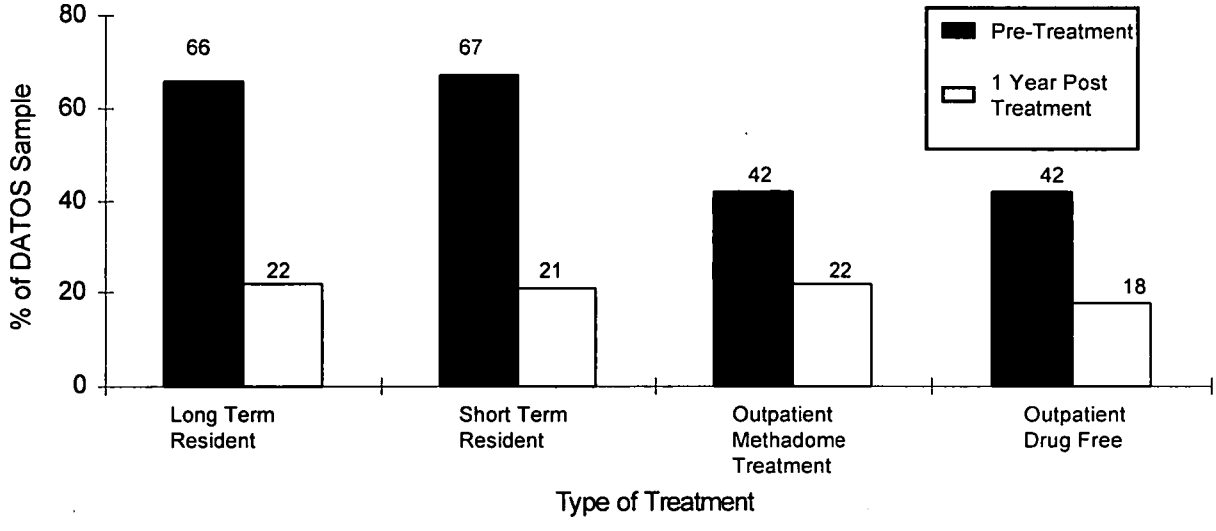
Group	Predicted Probability of Rearrest	Predicted Probability of Rearrest and Technical	Length of Time to Rearrest (days)
Jail Treatment Only	34.5%	55.0%	233
Jail/Community Tx	24.0%	36.00%	282
No Treatment	48.5%	68.00%	201

Source: Taxman, F and D. Spinner, 1997. Jail Addiction Services (JAS) Demonstration Project in Montgomery County, MD. University of Maryland, College Park.

Participation in drug treatment contributes to a significant reduction in the frequency of use and amount of drugs consumed. In the most recent Drug Abuse Treatment Outcome Study (DATOS) funded by the National Institute on Drug Abuse (NIDA), declines in drug use were reported for all treatment modalities. DATOS collected data on over 10,000 clients admitted to outpatient methadone treatment, short-term inpatient, long-term residential, and outpatient drug-free programs in 1991-1993. Follow-up data was collected on 3,000 clients one year after treatment. As shown in Exhibit 3, weekly drug use declined significantly between the pretreatment stage and the follow-up stage in all treatment modalities. In methadone treatment, daily or weekly heroin use fell from 89 percent at pretreatment to 28 percent at follow-up; cocaine use fell from 42 percent at pretreatment to 22 percent at follow-up. In other treatment modalities, clients reported at least a 50 percent reduction in weekly or daily cocaine use

compared to the pretreatment stage (Hubbard, et al., 1989; Simpson, et al., 1997b). In the W/B HIDTA study of 571 offenders participating in drug treatment for at least nine months, the researchers found that all of the offenders tested positive prior to treatment, with an average of 13 percent testing positive for drug use while in treatment (W/B HIDTA, 1997). Prior studies illustrate that when drug addicts are not actively using drugs, they are not engaging in criminal activity. In fact, Nurco and colleagues (1988) found that addicts in drug treatment were 75 percent less likely to commit crimes than when they were using drugs.

Exhibit 3:
Self Reported Drug Use Among Addicts Participating in Treatment (Cocaine Use)



Source: Simpson, D., et al., 1997. "DATOS First Wave Findings Release," Research Roundup. Texas Christian University: Institute of Behavioral Research

Skeptics of drug treatment cite doubts about the overall performance of the drug treatment system as evidence that treatment is not appropriate for offenders. A general impression is that drug treatment does little to change the behavior of addicts. High drop-out rates from drug treatment programs and relapse rates fuel concerns about ineffective services, with an average of 50 percent of addicts completing their course of treatment (Simpson, et al., 1997b). Such critics fail to recognize, however, that offenders have higher completion rates than volunteers for treatment services. Offenders also stay in treatment longer, complete treatment

programs, and report less drug use while in treatment programs than voluntary addicts in treatment (Simpson, et al., 1997; Hubbard, et al., 1989). In other words, while many use the overall experience of the treatment system to support the position that offenders do not deserve treatment, offenders benefit from treatment services and society benefits from offenders participating in treatment by less criminal behavior. The leverage of the criminal justice system can be used to improve public health and public safety outcomes.

Typical Barriers to Treatment; Added Bonuses of Providing Treatment for Offenders

The integration of drug treatment into the criminal justice system has been a struggle that underscores differing philosophies about criminal offenders, recovery, rehabilitation, and the value of leverage in changing the behavior of offender/addicts. Both the treatment and the criminal justice systems have struggled with allowing each other to achieve their own independent goals. The conflicting priorities and practices of the criminal justice and treatment systems often impact offenders accessing treatment programs, being placed in appropriate treatment programs, and using the leverage of the criminal justice system to retain the client in treatment. Many myths about treating offenders exist because of the failure of the treatment and criminal justice systems to develop systemic approaches to address common, but not insurmountable, issues. Some of the issues frequently cited as barriers to treatment for offenders are outlined below; research and good practices have generally countered these barriers.

TREATMENT IS PERCEIVED AS AN OPPORTUNITY, NOT A PUNISHMENT. While the criminal justice system has the goal of protecting society and reducing the risk from offenders, the public health system is primarily charged with the goal of providing services to improve health and social productivity. Harm reduction, in terms of criminal behavior, has never been a primary goal of treatment programs. It is only within recent years that the public health treatment system has

realized that treatment can be part of the strategy to reduce the demand for drugs and reduce criminal behavior. While treatment is not considered punishment, the coerced treatment model allows treatment to be a tool of the criminal justice system to deter drug use and crime. A related concern is that treatment is not punishment. Treatment programs are often portrayed as easy, minimally intrusive, and a privilege. The very nature of the treatment process requires addicts to change their lifestyles, behaviors, and daily habits. The treatment program restricts freedom by limiting the activities of the participants, limiting peer association, changing residence, and requiring participation in a variety of activities such as self-help groups, community service, etc. A recently noted trend emerging from several studies shows that 25 to 35 percent of offenders offered some the type of correctional treatment program refused the program with a preference for jail time (MacKenzie and Souryal, 1994; Petersilia and Turner, 1993). That is, offenders prefer incarceration to participation in a treatment program because the jail time is "easier time" than being held accountable for their behavior. Defense attorneys have commented that drug treatment programs are a risk for their clients because failure to comply with the program may result in clients serving more incarceration time (Taxman, 1994).

THE CRIMINAL JUSTICE OFFENDER IS OFTEN UNWANTED IN THE TREATMENT SYSTEM. While slightly less than 15 percent of the offender population is actually engaged in treatment services[1] (Drug Policy Strategy, 1996), one of the major stumbling blocks is that many public health agencies do not want to treat the criminal justice client. As discussed by Duffee and Carlson (1996), the attitudes and values of the treatment system often preclude prioritizing different populations for services. Part of this attitude derives from community agencies having

---

[1] Treatment services here include self-help groups, educational groups, therapeutic communities, group therapy, individual counseling, etc. Most of the services provided to offenders can be categorized as self-help groups and

their own perspective of the ideal client/offender, while the other part derives from the criminal offender being perceived as a "difficult client". Often, reporting to the court or probation agency is viewed as an additional burden that treatment programs do not want to handle.

With the exception of pregnant women and HIV active addicts, the first-come, first-served model of treatment services prevails in the public health system. Under the first-come, first-served model, everyone is viewed as equally needy for care. Addicts appearing at the door of the treatment program are accepted based on program-specific criteria which often do not include societal harm (e.g., criminal behavior) posed by the client. Under this model, it is easy for the treatment program to provide services to some sub-populations and not provide services to others. As noted by Schlesinger and Dorwart, the first-come first-served public health model allows treatment programs to select the clients they would like to serve and "avoid clients with the most difficult problems" (1993:224). Waiting lists are believed to be an artifact not only of clients needing services but of the organizational structure of the drug treatment provider system to pick and choose clients. There is no triage system in place to prioritize the type of addict that should receive care based on societal harm, matching of client to program, or any systematic process.

VOLUNTEERS ARE CONSIDERED MORE MOTIVATED THAN OFFENDERS, YET OFFENDERS HAVE BETTER TREATMENT COMPLETION RATES. A common myth is that the "treatment volunteers" are more motivated, and thus more willing, to change their behavior than addicts coerced into treatment. This assumption has not been substantiated. Research has shown that criminal justice offenders in treatment are more likely to complete their treatment than volunteers

---

educational groups. The actual percentage of offenders that participate in clinical interventions is much smaller than 15 percent of the offenders participating in any treatment services.

(Simpson, et al., 1981; Hubbard, et al., 1989). Most addicts do not "volunteer" for treatment services without some precipitating factor (such as the employer, the family or life partner, or some life crisis) to prompt the addict to seek treatment. These factors drive the client to seek treatment, as does the legal system. The "coercive factors" may provide the driving force to begin treatment but they do not provide the continuing pressure for a commitment to recovery. Recent research on motivation of addicts in treatment has shown that the treatment process can contribute to engaging the addict in treatment and motivating the client to change his/her behavior. That is, many clients may not be motivated initially, but the treatment process itself provides the client with tools which lead to a desire to change behavior, as well as to continue with treatment (Simpson, et al., 1997a).

OFFENDERS HAVE HIGHER COMPLETION RATES FROM TREATMENT PROGRAMS, THANKS TO THE LEVERAGE OF THE CRIMINAL JUSTICE SYSTEM. Both treatment and supervision agencies experience problems with compliance with program requirements. Findings of typical treatment programs indicate that at least half of the clients in treatment do not complete the program (Hubbard, et al., 1989). A widely reported problem with public health treatment programs is that dropout rates are typically high and relapse to drugs and criminality among dropouts is a problem (Hubbard, et al., 1989; Simpson, et al, 1997). Taxman and Byrne (1994) and Cunniff and Langan (1993) estimate that approximately 50 percent of offenders do not meet supervision requirements. Compliance problems create difficulties by reducing the integrity of the treatment and supervision programs.

With the oversight of the criminal justice system, criminal justice agencies have the leverage to motivate the offender to participate in treatment and complete the treatment regime. Studies have found that legal coercion is an important variable for the offender to stick with the treatment program (Anglin and Hser, 1990; Grella, et al., 1994; CASA, 1998). Many new

treatment initiatives for the criminal justice client feature graduated sanctions, or immediate consequences for non-compliance. The Drug Court pioneered the sanctions as a tool to encourage completion of treatment programs. The sanctions often involve rewards for good performance as well as punishment for continued drug use and failure to attend treatment programs. Results from the District of Columbia's Drug Court found that offenders are four times *less* likely to continue to use drugs when they are sanctioned (Harrell & Cavanaugh, 1996).

LENGTH OF STAY IN TREATMENT AND A CONTINUUM OF CARE INCREASE IMPROVED OUTCOMES. Length of stay in treatment has been found to be a critical variable in reducing recidivism and substance abuse (DeLeon, et al., 1982; Condelli and Hubbard, 1994; Hubbard, et al., 1989; Simpson, 1979; Simpson and Sells, 1990). Addicts are notorious for dropping out of treatment, especially during the early stages of a program when the addict is adjusting to a non-drug use lifestyle. Treatment programs have a difficult time engaging the client in treatment for a period sufficient to affect the behavior of the client. With high drop-out rates, it is difficult to achieve the desired outcomes of reduced consumption of drugs. The criminal justice involvement has the benefit of having an active, outside force to monitor compliance with treatment programs. Encouragement and reinforcement of the importance of the treatment program are part of the means to continue to engage the client in behavior change.

Managed care and cost containment efforts have led to shorter treatment programs, which result in reduced length of stay in treatment. A continuing trend in the field is minimizing services and reducing the length of time clients are in treatment (Etheridge, 1997). The implications for the future of this trend are unknown. However, researchers have supported the proposition that offender populations, due to the societal harm of criminal behavior, should participate in a minimum of one year of treatment (Lipton, 1995). It is recommended, as previously discussed, that treatment can be achieved by providing services in jail and/or prison and then continuing

treatment in the community. Providing for a continuum of care is one systemic process to increase the length of time in treatment by having offenders participate in different phases of treatment. The concept of a continuum extends the length of treatment while adjusting the intensity of the services based on the progress of the client. Several continuum models have been adopted: residential, jail or prison treatment, followed by outpatient; intermediate care (28 day residential) with intensive outpatient and outpatient; intensive outpatient and outpatient; and outpatient and aftercare. The continuum of care model provides the client with longer stays in treatment (up to 12 months), while reducing the costs of delivering services.

RECOGNIZING TREATMENT AS CRIME CONTROL IS GOOD PUBLIC POLICY. The coerced treatment model a crime control approach focused on behaviors that contribute to the criminal activity. By focusing efforts on offenders under supervision (e.g., probationers and parolees, in jail or prison), the behavior of these offenders can be monitored. Treatment is used to change the behavior of the offender by engaging the offender in services that address the substance abuse factors that drive criminal behavior. Treatment becomes the cornerstone of the sentence by reinforcing the importance of behavior change for the offender. Since the offender is under the control of the criminal justice system, oversight measures can be used to monitor the behavior of the offender. Drug testing is a favored technique to determine whether the offender is using drugs (Visher, 1990). Constant supervision and contacts with the addict is another mechanism to determine progress and then adjust treatment and criminal justice program components. Compliance measures (graduated sanctions) become tools to monitor the progress of the client and assist the offender in maintaining his/her commitment to recovery.

Moving from an Individual Case Management Approach to Systemic Case Management

Prior experience shows that providing treatment services for the criminal justice offender has been hampered by traditional barriers within the treatment and criminal justice systems. Traditionally, the criminal justice system has approached treatment as a brokered service, with the criminal justice system acting as a liaison by referring offenders for needed services. The perception of the criminal justice system has been that the treatment system has not met the needs of its clients (Cowles, et al., 1995; Duffee and Carlson, 1996). To address these unmet needs, the favored response has been to create case managers to bridge the criminal justice and treatment systems (Swartz, 1994). The underlying notion was that these case managers would provide the function of screening and assessing clients; they would work with the criminal justice system and treatment system to address differing philosophies and goals. The goal was for the case manager to be involved in issues of treatment placement, treatment plans, and non-compliance.

Recent research on demonstration projects involving the case management approach has not been as promising as expected (Martin, et al., in press; Taxman, et al., 1995). In the typical setting, the case manager is perceived as a supplement to the treatment process (Samson, et al., 1979) with case management services considered ancillary. The case manager often plays a critical role in the screening and assessment, but has a minimal role, if any, in treatment planning and treatment decisions (Sullivan, Hartmann, Dillon, and Wohl, 1994). For example, the Treatment Alternatives to Street Crime (TASC) evaluation recently found that case management is a diverse function that varies widely depending on the organizational structure; some case managers provide screening and assessment services and others are involved in actual treatment delivery (Anglin , et al., 1996). Anglin and colleagues found that case managers do not necessarily remain involved in treatment planning once the offender entered a

program. Several studies found that the role of the case manager was often unclear (Shwartz, et al., 1997) and that the case manager seldom consulted with parole officers to establish treatment goals for the offender (Martin, Inciardi, and Isenberg, 1993). Inciardi and Martin (1994) also noted that case manager roles parallel desired supervisory functions of probation and/or parole officers, which results in minimizing the role of the parole officer to monitor the offender when the case manager assumes such supervisory functions.

An overriding issue on case management is that the case manager's role is generally not perceived as a system function, but merely one of many actors involved with a client. The case manager role essentially is marginal, since each agency continues to act on its own accord. The client tends to have three interested parties—the supervision agent, the treatment provider, and the case manager—which creates difficulties when there are conflicting goals and expectations. Often this results in the client trying to resolve the conflict. In this scenario, each agency continues to function as if it is the only system, instead of an integrated part of a total system of care for the individual client. Studies have also found that individual case management practices do not produce system-wide changes because most case mangers cannot influence the distribution of resources available "within their local delivery systems" (Austin, 1993:453).

For the past ten years, researchers have identified a number of system features that are critical to effectively use treatment for offender populations. Primarily evolving from the individual case management movement (e.g., the Treatment Alternatives to Street Crime (TASC)) and the experiences of Stay 'n Out and other treatment initiatives for offenders, the following have been identified as critical components for an effective systems approach to treating the drug offender (Wexler, Lipton, & Johnson, 1988; Prendergast, Wellisch, and Anglin, 1994; Taxman and Lockwood, 1996; Taxman and Spinner, 1997; Anglin and Hser, 1990):

- Offenders must be assessed in terms of severity of drug use and propensity to commit crimes.
- Treatment placement should be made depending on the severity of drug use and propensity to commit crimes.
- Treatment must include an intensive component, followed by less intensive treatment, and then aftercare. The most effective treatment process is twelve months of care.
- Supervision and monitoring of the requirements are critical to improving treatment outcomes.
- External controls of supervision services (e.g., face-to-face, curfews, electronic monitoring, day reporting, etc.) should be used to control the offender in treatment and/or supervision programs.
- Sanctions or compliance monitoring should be used to deter clients from further drug use.
- Drug testing is critical to monitor drug use and deter offenders from further involvement in drugs.

The systemic case management approach integrates the above system features within the criminal justice and treatment systems as part of the ongoing processes for handling offenders. The systemic approach focuses on resource development, social action plans, policy formation, data collection, information management, program evaluation, and quality assurance (Austin, 1993). A systemic approach integrates traditional case management functions within the roles and responsibilities of the appropriate treatment and criminal justice staff. A third party is not responsible for performing these functions; instead, the treatment and criminal justice agencies function as a single agency instead of two separate units that try to "coordinate" fragmented services and constantly struggle over who "controls" decision-making about the client. The system predefines the components of care--testing, treatment, and supervision--that will be provided by the different agencies.

The cornerstone of a systems approach is that services consist of a process of interconnected parts. Treatment (e.g., therapeutic interventions, psychosocial education, etc.) and

criminal justice services (e.g., supervision, sanctions, community service, drug testing, electronic monitoring, house arrest, etc.) have specific value and meaning in the process. Rather than mere coordination, there is integration and synthesis in both policies and implementation. The systems approach lends itself to building the infrastructure to support the functions of a service delivery system with clearly defined policies relating to: assessment, referral, placement, tracking and monitoring, service planning, transitioning into the next level of care, appropriate service mix during all phases in the system, and discharge.

Lessons from the W/B HIDTA Seamless System of Treatment, Testing, and Sanctions

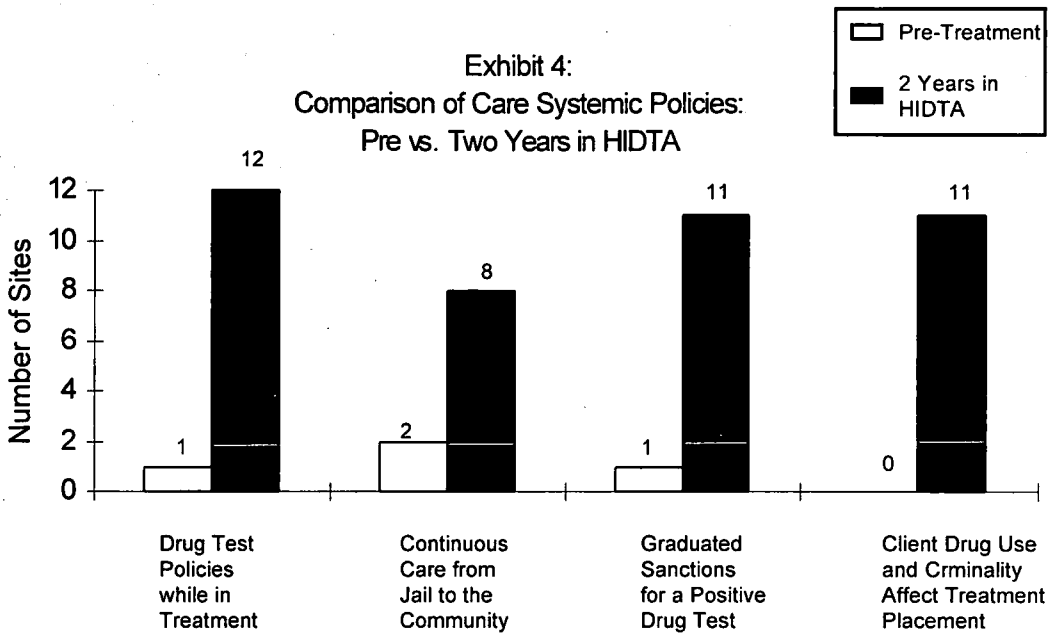
The purpose of the W/B HIDTA is to reduce the demand for drugs within the targeted jurisdictional area. As part of the mission, a treatment and criminal justice component assists with reducing the criminal behavior and the demand for drugs among hard-core substance abusing offenders, who typically recycle through the criminal justice system. By developing a systemic case management system between the criminal justice and public health systems, each jurisdiction is achieving these goals and objectives by establishing policies and practices in key areas: target population for treatment; appropriate treatment placement; drug testing; continuum of care; supervision; and sanctions or consequences for negative behavior. The common W/B HIDTA system goals are:

- To establish a "seamless" system between criminal justice and treatment agencies;
- To provide a continuum of care for the target offender population;
- To use drug testing to monitor performance in treatment and criminal justice supervision; and,
- To develop and implement graduated sanctions policies to increase compliance with the conditions of treatment.

Each jurisdiction uses these general goals to develop its seamless system. The seamless system is built with either a combination of jail-based treatment connected to treatment in the community, residential treatment with intensive outpatient, or intensive outpatient with outpatient care. The drug testing and sanctions with designated agents are common features in each jurisdiction.

Need for Policy Development

Exhibit 4 illustrates the progressive development of seamless system policies in the twelve jurisdictions participating in the W/B HIDTA. Prior to the W/B HIDTA, very few of the jurisdictions had drug testing policies, graduated sanctions, or a practice of a continuum of care that integrated treatment and criminal justice functions. As the jurisdictions participate in the project, more and more are adding components of the seamless system. The evolution of the seamless system concept is integral to changing management of the substance abusing offender in the community. The more treatment and criminal justice agencies agree on the principles of care for the individual, the better the expected outcomes. This explains the 85 percent retention rate in treatment for W/B HIDTA clients compared to a 50 percent rate for non-W/B HIDTA clients (Taxman, 1997). The core concepts are described below.



Source: Taxman, F., et al., 1997. "Case Studies of HIDTA Treatment and Criminal Justice Implementation," University of Maryland, College Park.

In a survey of jurisdictions participating in the W/B HIDTA, the researchers found that the existing policies and practices of treatment and criminal justice agencies did not specify the components of care of each system (e.g., treatment, criminal justice agencies, etc.). The treatment and criminal justice systems in these twelve jurisdictions had very little infrastructure in place to identify the types of offenders that should be prioritized for treatment services, the responses to positive urinalysis results, and drop-outs from treatment. For example, in one jurisdiction, very few of the sentenced offenders were receiving treatment services in the community. Instead, available treatment slots were being consumed by pretrial offenders who tended to quit treatment shortly after court disposition. Few stayed in treatment for more than 60 days, with an overall 66 percent drop-out rate (W/B HIDTA, 1997). A change in the screening and review process resulted in more sentenced offenders staying in treatment. This has also reduced the drop-out rates from treatment programs, since offenders are being closely monitored for treatment compliance.

Another area with little formal policy is drug testing. With the exception of the District of Columbia's Drug Court, none of the jurisdictions had a mechanism for sharing drug testing information between the treatment and criminal justice agencies. Many of the treatment programs refused to provide drug test results to criminal justice agencies as a matter of practice. If an offender is in treatment and tests positive, the treatment agency seldom informs the criminal justice agency until the end of the treatment program. Similarly, if clients are discharged from treatment, the criminal justice agency is usually informed within a three month period. These examples illustrate how the systemic case management approach addresses the linkage between the criminal justice and treatment agencies. By focusing on the typical problem areas—who gets access to treatment services, what should happen if the offender does not comply, and what type of information is useful to share among the agencies—the partnership is stronger. Failure to address these policy and practical issues has an impact on the public perception of the viability of treatment as an option for offenders.

The treatment continuum of care was also not a typical process. In ten jurisdictions, a process did not exist for moving the client along the treatment continuum of care. That is, if the offender participated in a jail-based treatment program, the system did not transition the offender to treatment services in the community. The jail-based treatment programs did not provide discharge services that included placement in a treatment program in the community. In fact, like other jail projects (Swartz, et al., 1996), many of the W/B HIDTA sites did not have good selection procedures. Often offenders participating in the jail treatment program are sent to prison after completion of the jail treatment program. The benefits from treatment will not be realized since these offenders are not likely to obtain treatment services in the prison systems. As part of the W/B HIDTA program, many jurisdictions developed selection criteria for the jail program that include the likelihood of the offender returning to the community, the offender having a minimum sentence in jail to participate in the program (which reduces early drop-outs), and the offender being on probation. These criteria provide policy guidance

to facilitate the continued treatment after release. Treatment planning for the community started as part of the jail treatment program. At several sites, probation/parole agents were assigned to the jail program to begin the transition to the community. Treatment programs in the community were selected to ensure that the offender had a ready placement. Policies were developed both in terms of target population and the transition approach to ensure that offenders participating in jail treatment were eligible for community treatment programs and placement followed release from jail.

Evaluation Findings

The question arises as to the impact of policy development on the two goals of treatment: retention and recidivism for clients. As part of the evaluation, the researchers have tracked over 1,700 offenders that have been exposed to the seamless system concepts of a continuum of care, graduated sanctions, and drug testing. This is an early stage of the development of the seamless initiatives with most features in place for slightly over one year. Preliminary findings illustrate how seamless policies can improve client outcomes.

CHARACTERISTICS OF OFFENDERS IN TREATMENT. The average W/B HIDTA client is 33 years old and male, with 69 percent African-American and 26 percent Caucasian. The primary drug of choice is crack cocaine (43 percent) and heroin (28 percent). Twenty (20) percent indicate that they are intravenous drug users; the majority smoke or inhale their drugs. Over 69 percent of the offenders reported using drugs at least daily with half of those indicating more than once a day use of drugs.

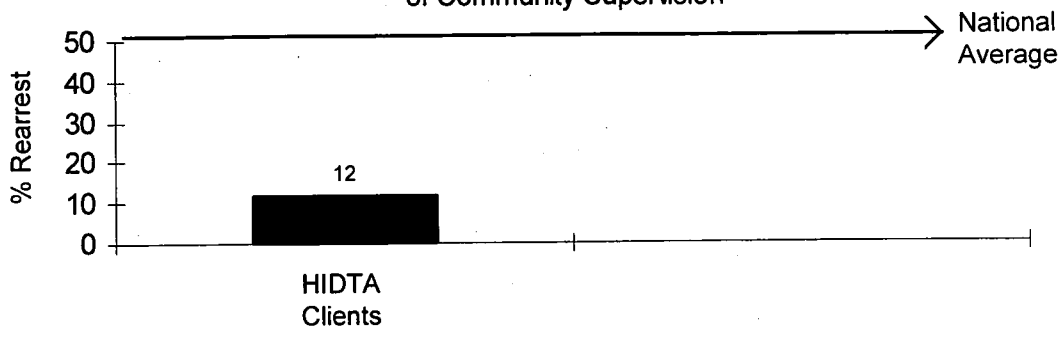
The average W/B HIDTA offender has nine prior arrests and five prior convictions. The arrest history is indicative of offenders that have multiple experiences with the criminal justice system. For the instant offense, 23 percent of the offenders had a property crime, 18 percent

were arrested on possession of drugs, 26 percent were arrest for distribution or intent to distribute drugs, and 10 percent had a violation of probation/parole.

RETENTION IN TREATMENT. One purpose of the seamless system approach is to improve retention in treatment programs. As previously indicated, nearly 50 percent of the addicts in treatment drop out of treatment (Simpson, et al., 1997b). As part of the W/B HIDTA treatment initiative, we found that 72 percent completed the first phase of treatment and 62 percent continued treatment in the second phase. The overall retention rate in the treatment process is 85 percent, which is based on the results for over 1700 offenders, many of whom are still active in the treatment process.

REARREST RATES DURING 9 MONTHS OF SUPERVISION WHILE IN TREATMENT. To assess the impact of the process on rearrest rates, the evaluators collected rap sheets for 571 offenders who have participated in the W/B HIDTA treatment. This includes only offenders who are in the community for 9 months. All program participants (e.g., including drop-outs) are included in the sample. Prior to participation in the seamless system, the average HDITA client was arrested once every 9 months. The base rate for rearrest rates for multiple offenders is 50 percent. With the W/B HIDTA process of a continuum of care, testing, and sanctions, the researchers found that 12 percent of the offenders were arrested for new crimes during 9 months in the community. As shown in Exhibit 5, this is significantly less than was expected given the history of the clients. The retention in treatment, as previous research has demonstrated, appears to be reducing criminal behavior.

Exhibit 5:
Percent of Offenders Rearrested During Nine Months of Community Supervision



Source: W/B HIDTA, 1997

Twelve Principles for Effective Systems of Care Focusing on Transitional Policies and Treatment Retention

The underlying functionality of the treatment and criminal justice system in any region will largely determine the results of individual treatment programs for offenders. Below are the principles of effective systems of care that are designed to: 1) reduce recidivism, and 2) increase retention in treatment programs. These two goals are commingled to allow quality treatment to impact reductions in recidivism. Providing good quality treatment has been demonstrated to reduce recidivism (Anglin & Hser, 1990; Wexler, et al., 1988; Lipton, 1995; Taxman & Spinner, 1997; Inciardi, et al., 1996; Knight, et al., 1997; CASA, 1998). The question is: what are the most effective approaches to achieve reductions in recidivism?

RECIDIVISM REDUCTION SHOULD BE THE GOAL OF THE CRIMINAL JUSTICE AND TREATMENT SYSTEM. Under the current arrangement, treatment and criminal justice systems have two differing goals, neither of which is directly focused on reducing recidivism. Having a stated goal of treatment and criminal justice supervision to reduce recidivism focuses interventions on this goal. The emphasis on recidivism reduction brings the systems into alignment, requires each to rethink operations and priorities for the agencies individually and operating jointly, and

reallocates resources. By examining the current distribution of resources, the efforts are on how best to deliver effective services (instead of any services) to achieve the goal of reducing recidivism.

TREATMENT AND CRIMINAL JUSTICE SYSTEM FEATURES MUST BE POLICY DRIVEN. The seamless system features—integrated screening, placement, testing, monitoring, and sanctions—do not typically exist. The recognition that these policies are critical to effective service delivery requires the systems to develop supporting policies, as described below.

A policy-driven forum is needed to develop and implement targeted policies and practices. Various players of the system, including administrators of the treatment/health, probation and parole, jail, law enforcement officials, judges, court administrators, and other criminal justice or social agencies, must work together as a policy team. Often the inclusion of representatives of the executive and legislative bodies is very important to develop a consensus on policies to make system-wide changes. The policy team approach is a critical component to addressing system issues that tend to be grounded more in tradition than in effective practices. Since it is often difficult to obtain interagency consensus around a common goal like recidivism reduction, the goal provides a mechanism to address organizational or turf battles that are perceived as sacred cows (Woodward, 1993). The policy team and goal driven strategy are designed to develop a consensus for the "seamless" system components in each jurisdiction and then develop the surrounding protocols.

TREATMENT AND CRIMINAL JUSTICE MUST FUNCTION AS A TEAM. The work of the policy team is to define and develop policy as well as provide the needed resources. The next step is to carry policy into practice and operation. The policies serve as a guide to operating procedures by providing direction to staff in dealing with ongoing, daily issues. For example, a policy which states that drug test results will be shared between the criminal justice and treatment

systems is designed to ensure that both agencies are informed of the client's progress. The policy directs the supervisors and staff to develop a mechanism for sharing drug test information on a timely basis. At the staff level, this removes the potential for individual staff members to make individual decisions about whether or not they desire to share drug test results. It also provides an agency process to share drug test results such as faxing positive results, using interagency automated systems, etc.

A team approach assists the criminal justice and treatment systems to become partners in the care of the individual offender in treatment. Instead of being adversaries, the criminal justice and treatment staff are working together. The policies guide the relationship by specifying the nature of the working relationship in operational terms focused on: target populations, treatment selection, supervision standards, drug test results, and sanctions. Traditional barriers of information dissemination, confidentiality concerns, and uncertainties about how information will be used disappear by working through these issues as a team.

USE DRUG TESTING TO MANAGE OFFENDERS. Urinalysis allows for immediate confirmation of an offender's use of drugs. While it is clearly a tool for both the treatment and criminal justice systems, drug testing results have not been integrated into policies on how to handle offenders. While many systems test offenders, few systems have policies that use drug test results to screen offenders for treatment programs. Even fewer systems have policies in effect which provide guidelines on how to handle positive drug tests while the offender is in treatment or under supervision. Treatment placement and program compliance are two areas which require standards and practices. Working together as a team will allow the systems to use available drug test resources widely. Funding for drug testing comes from different sources (e.g., treatment programs, probation, courts, etc.). Few agencies are aware of the testing done by other agencies. Additionally, treatment and supervision agencies have different testing schedules, which include the types of drugs that are tested, frequency of taking

specimens, and different levels to indicate a positive urine. Since drug test results are seldom shared, the other agency is often unaware of those results or the surrounding factors that affect test results. Drug tests have not been integrated into practice as a tool to manage the offender in the community.

The Department of Justice's recent requirement on drug testing polices for offenders provides an outline of many pertinent issues related to drug testing that need immediate policy and operational attention (U.S. Department of Justice, 1996). At a minimum, treatment and criminal justice agencies need to consider the overall use of testing in the system. For example, which offenders will be tested while in treatment? During the period of supervision? Who will be responsible for the testing? If testing is to be used to manage treatment and supervision compliance, what should be the responses to positive urine results? These are all policy issues that dramatically affect operations. If testing is to be used to detect potential relapses (including involvement in the criminal justice system), then the criminal justice and treatment systems must work together to ensure that their operations support recidivism reduction practices.

TARGET OFFENDERS FOR TREATMENT WHERE TREATMENT CAN "WORK" Targeting is probably one of the most difficult issues in corrections and criminal justice policies. Boot camps, drug treatment programs, intensive supervision, and other correctional innovations have all experienced difficulties with the targeting problem (Austin, et al., 1994; Byrne, et al., 1992; Andrews and Bonta, 1994). The tendency is often to provide services to "low risk" offenders, which some contend reduces the societal impact of the treatment programs (Andrews and Bonta, 1994). To have an impact on recidivism and drug consumption, the focus should be on offenders that are both addicts as well as criminally active. By definition, this is the individual with significant years of abusing drugs and prior experience with the criminal justice system.

Both criminal justice and treatment issues must define the target definition for secure treatment resources. From the criminal justice perspective, the offender with a prior arrest and

conviction history is more likely to be causing harm to the community. That is, offenders' substance abuse habits drive their criminal behavior in such volume that the individual is likely to be committing many crimes. Cautious decisions must be considered in selecting offenders. First, the criminal justice history may also dictate that the offender is likely to be incarcerated for long periods of time. Targeting these offenders is likely to have little impact on crime in the community. Next, the legal status is an important variable. Many pretrial offenders use participation in treatment to convince judges of their sincerity about their substance abuse problems, only to drop out of treatment after the criminal charge has been dismissed or the offender is placed on probation. The focus on the sentenced offender has several advantages, including the offender is more likely to continue with treatment as part of the requirement of supervision, the offender is less likely to drop out of treatment, and the offender is more likely to be motivated to change his/her behavior over the long period of supervision. The recidivism reduction potential is therefore not likely to be realized for those offenders.

From the clinical perspective, treatment should be targeted to offenders who will benefit from the services. Sociopathic offenders are unlikely to benefit from most community-based treatment programs. For example, the Maryland Department of Public Safety and Correctional Services uses the Psychopathic Checklist - Revisited to identify offenders suitable for treatment. Criminogenic offenders are also unlikely to benefit from programs that do not address the criminal thinking skills and criminal values. While some contend that the offender's motivation should be a clinical factor affecting selection decisions, recent strides in treatment processes illustrate that quality treatment programs can address motivational factors (Simpson, et al, 1997a). The use of standardized instruments to measure personality disorders, psychological functioning, and motivation provide system processes to select offenders for treatment.

Three other treatment issues are the severity of drug use, type of drugs used, and prior treatment experience. Severity of drug use might be an indicator of need, with priority given to addicts that have daily habits compared to those with less frequent usage patterns (e.g., binge behavior, weekly use, etc.). Similarly, the type of drug abused might also be an important factor in determining priority for treatment given the knowledge that some addicts are more criminally active than others. Finally, prior treatment experience may be a useful variable to determine appropriateness of an offender for a particular type of program. Standardized instruments can ensure that treatment and criminal justice staff collect consistent information on clients, as well as make decisions based on agency priorities. Some agencies use instruments like the Addiction Severity Index as a guide to alcohol and drug problems and use the composite score of 4 and above to indicate addicts who tend to be more harmful to the community (Williams and Spingarn, 1997).

The integration of treatment and criminal justice information in targeting decisions is frequently discussed, but infrequently applied. The difficulty in administering the policy is that treatment and criminal justice agencies do not share information gathered in their respective disciplines. Often the treatment system does not have criminal justice information, other than self reported criminal justice history. Conversely, criminal justice agencies often rely on the offender to report prior treatment experience and drug use patterns. The focus on recidivism reduction policies will require triaging available treatment slots for offenders that create harm in the community by their drug use *and* criminal behavior. Ultimately, criminal justice and treatment agencies will have to determine how to gather and use information from the different systems to make triage decisions.

USE TREATMENT MATCHING PRACTICES. The tendency of most systems is to place offenders in the first available treatment slots. Often the available "slot" is not suitable for the

needs of the offender, but merely reflects an opening. However, using information gathered for targeting purposes, more informed decisions can be made about the type of offender who should be placed in residential, intensive outpatient, and outpatient programs. A mixture of treatment needs and criminal justice risk factors can assist in making this determination. For example, offenders with more involvement in the criminal justice system are likely to require more external controls (e.g., residential or intensive outpatient settings with more structure, etc.) on their behavior as compared to those with less prior criminal justice history. Since many jurisdictions have some services in the jail or prison, consideration should be given to the continuity of care (e.g., suitability of the treatment philosophy and approaches) from the jail/prison program to the community-based program. The American Society of Addiction Medicine has developed a protocol for treatment placement (ASAM, 1991). Although this protocol does not include criminal justice risk factors, policy teams can modify their approaches to incorporate treatment and criminal justice needs.

CREATE A TREATMENT PROCESS AND EXTEND THE LENGTH OF TIME IN TREATMENT. Research continues to affirm the importance of the length of time in treatment for addicts, with better results usually occurring from longer participation in treatment programs. Many short-term residential and outpatient treatment programs are four months or less in duration (Etheridge, et al., 1997); few long-term residential programs (greater than six months) exist. The W/B HIDTA program adopted the continuum of care concept to increase the length of time in treatment for the offender by providing a treatment process of several different programmatic components—more intensive services (e.g., residential, jail/prison-based, day programs, etc.) followed by less intensive, traditional outpatient services. The goal is to engage the offender in treatment for longer periods of time with the treatment process consisting of program phases. The combination of intensive and less intensive services results in a less intrusive treatment environment, as well as being cost effective.

Since most treatment and correctional systems thrive on episodic treatment experiences, policies are required to create the continuum of care practices at the individual level. It is not sufficient to have an array of services without the supporting policies to move offenders through the continuum. These policies need to address the following: 1) establishing a reservation system to alert programs of the expected date of placement in their program; 2) creating a behavioral contract to inform the offender of the likely continuum; 3) establishing criteria for placing offenders in different treatment programs based on progress in the subsequent treatment program; 4) training criminal justice and treatment personnel on the use of a continuum; and, finally, 5) establishing treatment policies which step up or step down the level of care based on progress.

ALLOW BEHAVIORAL CONTRACTS TO BIND THE OFFENDER, THE TREATMENT SYSTEM AND CRIMINAL JUSTICE SYSTEM. A behavioral contract is tool of the treatment and criminal justice systems to specify the expectations for the client as well as identify treatment and criminal justice services. Informing the offender of the programmatic components clarifies the treatment and criminal justice experiences. Core components of the contract are: 1) treatment programs assigned to and hours of therapy (e.g., each phase or treatment program should be specified, including jail-based treatment programs); 2) supervision schedule and location of supervision agent; 3) drug testing schedule; 4) graduated sanctions to identify set responses to common issues such as positive drug tests and missed appointments; 5) incentives; and 6) special conditions of treatment and/or supervision (e.g., community service hours, electronic monitoring, house arrest, self-help groups, etc.). The behavioral contract should be signed by the offender, treatment provider, and criminal justice agent (and potentially the judge) to serve as a binding contract. The contractual component of the plan requires all parties to be equally committed to the different phases of the treatment and criminal justice protocol.

DESIGNATE SPECIAL AGENTS FOR SUPERVISING OFFENDERS IN TREATMENT PROGRAMS. To become a team with treatment, the probation and/or criminal justice staff must understand the

treatment process and support treatment goals. This requires a close working relationship among the treatment and criminal justice staff. The team process in a seamless system relies on the staff to be considerate and supportive of the roles and needs of each discipline. Essentially, specialized agents ensure that a core component of criminal justice staff understand the recidivism reduction principles along with treatment issues.

With a core staff, it is feasible to use the tools of corrections to control the behavior of the offender in the community and to increase compliance with treatment and criminal justice requirements. Probation involves a number of functions that can improve the integrity of the treatment process such as drug testing (to confirm abstinence), collateral contacts (to identify potential problems in the community, etc.), face-to-face contacts (to observe and discuss treatment progress and compliance with general court conditions), and community service (to help repay society for the crime and to fulfill sentence obligations). In addition, the probation officer can modify most conditions of the sentence (within a range) to intensify the structure should the offender have difficulties in the treatment/supervision or reduce supervision/structure through treatment services. The supervision services offer the potential to enable and facilitate all services by monitoring the offender's performance. Supervision provides the leverage of the criminal justice system to keep the offender in the appropriate treatment services (Visher, 1990; Collins and Allison, 1983).

SANCTION NON-COMPLIANT BEHAVIOR. A cornerstone of recidivism reduction policies addresses the area of non-compliance, or the "what to do with" practices of how to address offenders who fail to fulfill treatment or supervision conditions. Contingency management, token economies, and behavior modification systems are systemic practices that are used in the treatment field to address compliance. Sanctions provide the tools to hold offenders accountable under their behavioral contract. The sanctions are essentially preventive measures to reduce

revocations and recidivism, as demonstrated by the D.C. Drug Court (Harrell & Cavanaugh, 1996).

Sanctions policies must have four components. First, the infractions or violation behavior must be clearly identified. By informing the offender of the negative behavior, the process clarifies expectations for the offender. Typical infraction behaviors are positive urine tests, missed appointments in treatment or supervision, and failure to abide by program conditions. Second, the sanctions must be swift, or occur shortly after the behavior at issue. As a rule, it is important to have the sanctions occur within 24 hours of the behavior, which reduces the denial of the behavior by the offender. Such a policy also requires the treatment and criminal justice systems to respond appropriately to potential crime-producing behavior. Third, the sanctions must be certain or clearly specified, so that the offender is aware of the consequences for violating the treatment and supervision norms. An example of certain responses includes specified days in jail, hours of community service, or increased reporting requirements. The certain responses clarifies for the offender that the lack of compliance will result in a negative response. The final component of the sanction schedule is the progressive nature of the responses. It is unlikely that the response for negative behavior will be the same each time the offender fails to comply. Instead, a sanctions schedule increases in severity as the offender continues to persist in violating treatment and supervision rules. An example is the following: the first positive urine results in one day in jail, the second positive urine results in three days in jail, and the third positive urine results in five days in detoxification. This type of progressive schedule makes clear that the consequences become more severe as the offender continues to persist in his/her negative behavior.

Developing a set of polices that are agreed upon by the criminal justice system will require input from treatment providers, criminal justice actors, and the judiciary[2]. Most treatment programs and probation agencies have their own individualized policies addressing noncompliance with program conditions. In the seamless system, the systems agree on a set protocol as mechanism to reduce recidivism. The agreed-on policies then help to ensure that treatment and criminal justice agencies respond appropriately to infractions; this reduces the likelihood that staff will not respond to non-compliant behavior.

REWARD POSITIVE BEHAVIOR. Infrequently the criminal justice system acknowledges positive achievements made by offenders. An incentive system, similar to a sanctions schedule, provides an opportunity to formalize recognition for good behavior so that restraints on the offender are reduced as progress occurs. An incentive system should be swift, certain, and progressive in the same fashion as a sanctions system. The system provides the positive reinforcements often missing from the criminal justice and treatment systems. Positive incentives provide a rationale for the offender to comply with treatment and criminal justice conditions and rewards the attainment of individual goals. In a seamless process, the good and the bad must be equally recognized.

FOCUS ON QUALITY, NOT QUANTITY. The seamless system underscores the importance of policy-driven practices to reduce recidivism. A critical component of recidivism reduction practices is improving outcomes of offenders. Generally this involves ensuring that the treatment and criminal justice systems have the appropriate quality control measures in place to fulfill their

---

[2] The use of sanctions may be affected by the statutory authority of the probation and/or parole agents in a given jurisdiction. In some jurisdictions, probation and/or parole officers cannot incarcerate an offender without approval of the judiciary. In other jurisdictions, the agents have the authority. Since the probation department is generally responsible for executing court orders, the sanction schedules should be developed in coordination with the criminal justice system, particularly judges.

obligations. This may require reallocating existing resources to commit to the desired outcomes. It also may result in some short time changes in the number of offenders that can be served through the process. Many agencies operate from a mindset of trying to serve the maximum number of clients possible. Although criminal justice agencies seldom have the opportunity to limit their "clientele", the seamless system process provides the forum to focus on outcomes. Tide to this is the realization that quality programs and services produce these outcomes. That is, each system may determine that existing resources available in the treatment and criminal justice systems can sufficiently provide quality services to a set number of offenders. Squeezing more clients into the process may dilute its effectiveness.

An important component of quality is in the type of treatment services offered. The tendency of the criminal justice system is to offer less intensive, less expensive services. Self-help groups and educationally oriented services (although valuable service units) dominate the field (CASA, 1998). Yet, to achieve the gains from treatment, other clinical services are needed (e.g., therapeutic community, cognitive behavior skills, milieu therapy, etc.) (Lipton, 1995; Andrews and Bonta, 1994). The focus on outcomes helps systems redefine their service systems on quality or services that are more likely to change behavior. The emphasis on scientifically proven interventions will show gains in better outcomes.

Summary

Effective treatment services are synonymous with effective criminal justice services. The seamless system protocol provides a systemic process to address some of the criticisms of the existing service offered by treatment and criminal justice agencies. It removes discretionary practices and institutionalizes operations to address the traditional barriers to treatment for offender populations. Many scholars, policy makers, and practitioners highlight how critical it is

to provide good treatment services to ensure that the public has confidence in criminal justice polices. Through the seamless system approach, it is feasible to ensure that these policies become operational.

References

American Probation and Parole Association and NASADAD. 1992. *Coordinated Interagency Drug Training Program.* Lexington, KY: APPA.

American Society of Addiction Medicine. 1991. *Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders.* Washington, DC.

Andrews, D. A. and J. Bonta. 1994. *The Psychology of Criminal Conduct.* Cincinnati, OH: Anderson Publishing.

Andrews, D. A., I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau and F. T. Cullen. 1990a. "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis." *Criminology* 28:369-404.

Andrews, D. A., I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau and F. T. Cullen. 1990b. "A Human Science Approach or More Punishment and Pessimism: A Rejoinder to Lab and Whitehead." *Criminology* 28:419-429.

Anglin, M. D. and Y. Hser. 1990. "Treatment of Drug Abuse." Pp. 393-460 in *Drugs and Crime,* edited by Michael Tonry and James Q. Wilson. Chicago, IL: University of Chicago Press.

Anglin, M. D., Hser, Y., & Grella, C. E. 1997. "Drug Addiction and Treatment Careers Among Clients in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11:308-323.

Anglin, M. D., D. Longshore, S. Turner, D. McBride, J. Inciardi and M. Prendergast. 1996. *Studies of the Functioning and Effectiveness of Treatment Alternatives to Street Crime (TASC) Programs: Final Report.* Los Angeles, CA: UCLA Drug Abuse Research Center.

Ball, J. C. and A. Ross. 1991. *The Effectiveness of Methadone Maintenance Treatment: Patients, Programs, Services, and Outcomes.* New York: Springer-Verlag.

Belenko, S., J. A. Fagan and T. Dumanovsky. 1994. "Effects of Legal Sanctions on Recidivism in Special Drug Courts." *Justice System Journal* 17:53-81.

Byrne, J.M., and A. Pattavina, 1992. "The Effectiveness Issue: Assessing What Works in the Adult Community Corrections Systems," in J. M. Byrne, A. J. Lurigio, and J. Petersilia, *Smart Sentencing: The Emergence of Intermediate Sanctions,* Sage Publications.

Byrne, J. M. 1990. "The Future of Intensive Probation Supervision and New Intermediate Sanctions." *Crime and Delinquency* 36:6-41.

Byrne, J. M., A. Lurigio and C. Baird, 1989. "The Effectiveness of the 'New' Intensive Supervision Programs." *Research in Corrections* 5:1-70.

Center on Addiction and Substance Abuse at Columbia University (CASA). 1998. *Behind Bars: Substance Abuse and America's Prison Population.* New York City, New York: National Center on Addiction and Substance Abuse at Columbia University.

Collins, J. J. and M. Allison. 1983. "Legal Coercion and Retention in Drug Abuse Treatment." *Hospital and Community Psychiatry* 34:1145-1149.

Condelli, W. S. and R. L. Hubbard. 1994. "Relationship Between Time Spent in Treatment and Client Outcomes from Therapeutic Communities." *Journal of Substance Abuse Treatment* 11:25-33.

Cook, F. 1992. "TASC: Case Management Models Linking Criminal Justice and Treatment." Pp. 368-382 in *Progress and Issues in Case Management*, edited by R. S. Ashery. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 127.

Cowles, E. L., T. C. Castellano and L. A. Gransky. 1995. *'Boot Camp' Drug Treatment and Aftercare Interventions: An Evaluation Review.* Washington, DC: National Institute of Justice.

DeLeon, G. 1988. "Legal Pressure in Therapeutic Communities." Pp. 160-177 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

DeLeon, G., H. K. Wexler and N. Jainchill. 1982. "The Therapeutic Community: Success and Improvement Rates 5 Years After Treatment." *International Journal of the Addictions* 17:703-747.

Donovan, D. M. 1990. "Coming Out of the Fog: Professional Practice Issues in the Addictions in the Decade of the 1990s." *Psychology of Addictive Behaviors* 4:42-44.

Drug Policy Strategies, 1997. *Keeping Score.* Washington, D.C.

Duffee, D and B. Carlson, 1996. "Competing Value Premises for the Provision of Drug Treatment to Probationers,' *Crime and Delinquency*, Vol 42 (4): 574-593.

Etheridge, R. M., Hubbard, R. L., Anderson, J., Craddock, S. G., & Flynn, P. M. (1997). Treatment Structure and Program Services in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11:* 244-260.

Falkin, G. 1993. *Coordinating Drug Treatment for Offenders: A Case Study.* New York: National Development and Research Institutes, Inc.

Gendreau, P. 1996. "Offender Rehabilitation: What We Know and What Needs to Be Done." *Criminal Justice and Behavior* 23:144-161.

Gerstein, D. R., R. A. Johnson, H. J. Harwood, D. Fountain, N. Suter and K. Malloy. 1994. *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA).* Sacramento, CA: State of California, Health and Welfare Agency, Department of Alcohol and Drug Programs.

Gustafon, J. S. 1991. "Do More and Do It Better: Staff Related Issues in the Drug Treatment Field that Affect Quality and Effectiveness of Services." Pp. 53-62 in *Improving Drug Abuse Treatment*, edited by R. W. Pickens, C. G. Leukefeld and C. R. Schuster. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 106.

Harrell, A. and S. Cavanagh. 1996. *Preliminary Results from the Evaluation of the DC Superior Court Drug Intervention Program for Drug Felony Defendants.* Washington, DC: National Institute of Justice.

Harwood, H. J., R. L. Hubbard, J. J. Collins and J. V. Rachal. 1988. "The Costs of Crime and the Benefits of Drug Abuse Treatment: A Cost-Benefit Analysis Using TOPS Data." Pp. 209-235 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No 86.

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

Hubbard, R. L. and M. T. French. 1991. "New Perspectives on the Benefit-Cost and Cost-Effectiveness of Drug Abuse Treatment." Pp. 94-113 in *Economic Costs, Cost-Effectiveness, Financing, and Community-Based Drug Treatment*, edited by W. S. Cartwright and J. M. Kaple. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 113.

Kleiman, M. R. 1997. "Drug Free or Unfree: To Get Heavy Users to Stay Clean, Link Parole and Probation to Abstinence." *Washington Post*, February 2:C3.

Knight, K., D.D. Simpson, I.R Chatham, and L.M Camacho, 1997. "An Assessment of Prison-Based Drug Treatment: Texas' in-prison therapeutic Community Program," *Journal of Offender Rehabilitation*, 24 (3/4), 75-100.

Leukefeld, C. G. and F. M. Tims. 1988a. "Compulsory Treatment: A Review of Findings." Pp. 236-251 in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

Leukefeld, C. G. and F. M. Tims (Eds.). 1988b. *Compulsory Treatment of Drug Abuse: Research and Clinical Practice.* Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 86.

Leukefeld, C. G. and F. M. Tims. 1990. "Compulsory Treatment for Drug Abuse." *International Journal of the Addictions* 25:621-640.

Lipsey, M. W. 1990. *Design Sensitivity: Statistical Power for Experimental Research.* Newbury Park, CA: Sage Publications.

Lipton, D. S. 1995. "The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision." Presentation at the Conference on Criminal Justice Research and Evaluation. Washington, DC: National Institute of Justice.

Lockwood, D. and J. A. Inciardi. 1993. "CREST Outreach Center: A Work Release Iteration of the TC Model." Pp. 61-70 in *Innovative Strategies in the Treatment of Drug Abuse: Program Models and Strategies*, edited by J. A. Inciardi, F. Tims and B. Fletcher. Westport, CT: Greenwood Press.

MacKenzie, D. L. and C. Souryal. 1994. *Multi-Site Evaluation of Shock Incarceration.* Washington, DC: National Institute of Justice.

Martin, S. S. and J. A. Inciardi. 1996. "Case Management Outcomes for Drug Involved Offenders." Presentation at the American Society of Criminology Meeting in Chicago, IL.

Martin, S. S., J. A. Inciardi, F. R. Scarpitti and A. L. Nielsen, in press. "Case Management for Drug Involved Parolees: A Hard ACT to Follow." In *The Effectiveness of Innovative Approaches to Drug Abuse Treatment*, edited by J. A. Inciardi, F. M. Tims and B. W. Fletcher. Westport, CT: Greenwood Press.

Metja, C., P. J. Bokos, J. H. Mickenberg and E. M. Maslar. 1994a. "Case Management with Intravenous Drug Users: Implementation Issues and Strategies." Pp. 97-113 in *Drug Abuse Treatment: The Implementation of Innovative Approaches*, edited by B. W. Fletcher, J. A. Inciardi and A. M. Horton. Westport, CT: Greenwood Press.

Metja, C. L., P. J. Bokos, J. H. Mickenberg, E. M. Maslar, A. L. Hasson, V. Gill, Z. O'Keefe, S. S. Martin, H. Isenberg, J. A. Inciardi, D. Lockwood, R. C. Rapp, H. A. Siegal, J. H. Fisher and J. H. Wagner. 1994b. "Approaches to Case Management with Substance Abusing Populations." Pp. 301-319 in *Addictions: Concepts and Strategies for Treatment*, edited by J. A. Lewis. University Park, IL: Aspen Publishers, Inc.

Moore, S. T. 1990. "A Social Work Practice Model Of Case Management: The Case Management Grid." *Social Work* 35:444-448.

Moore, S. T. 1992. "Case Management and the Integration of Services: How Service Delivery Systems Shape Case Management." *Social Work* 37:418-423.

National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD). 1992. *State Resources and Services Related to Alcohol and Other Drug Abuse Problems.* Washington, DC: NASADAD.

Netting, E. F. 1992. "Case Management: Service or Symptoms?" *Social Work* 37:160-164.

Nurco, D. N., T. W. Kinlock, T. E. Hanlon and J. C. Ball. 1988. "Non-Narcotic Drug Use Over An Addiction Career: A Study of Heroin Addicts in Baltimore and New York City." *Comprehensive Psychiatry* 29:450-459.

Palmer, T. 1992. *Re-Emergence of Correctional Intervention.* Newbury Park, CA: Sage Publications.

Palmer, T. 1995. "Programmatic and Nonprogrammatic Aspects of Successful Intervention: New Directions for Research." *Crime and Delinquency* 41:100-131.

Parent, D., J. Byrne, V. Tsarfaty, L. Valade and J. Esselman. 1995. *Day Reporting Centers.* Washington, DC: National Institute of Justice.

Peters, R. H. 1993. "Drug Treatment in Jails and Detention Settings." Pp. 44-80 in *Drug Treatment and Criminal Justice,* edited by J. A. Inciardi. Newbury Park, CA: Sage Publications.

Peters, R. H., W. D. Kearns, M. R. Murrin and A. S. Dolente. 1992. "Effectiveness of In-Jail Substance Abuse Treatment: Evaluation Results from a National Demonstration Program." *American Jails* 6:98-104.

Peters, R. H. and R. L. May. 1992. "Drug Treatment Services in Jails." Pp. 38-50 in *Drug Abuse Treatment in Prisons and Jails,* edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 118.

Petersilia, J. 1989. "Implementing Randomized Experiments: Lessons From BJA's Intensive Supervision Project." *Evaluation Review* 13:435-458.

Petersilia, J. and S. Turner. 1992. "An Evaluation of Intensive Probation in California." *Journal of Criminal Law and Criminology* 82:610-658.

Petersilia, J. and S. Turner. 1993. *Evaluating Intensive Supervision Probation/Parole: Results of a Nationwide Experiment.* Washington, DC: National Institute of Justice.

Prendergast, M. L., M. D. Anglin and J. Wellisch. 1994. "Community-Based Treatment for Substance-Abusing Offenders: Principles and Practices of Effective Service Delivery." Presentation at This Works! Community Sanctions and Services for Special Offenders: A Research Conference. International Association of Residential and Community Alternatives.

Schlesinger, M. and Dorwart, R. A. 1993. "Falling Between the Cracks: Failing National Strategies for the Treatment for Substance Abuse," Daedalus. 121 (3): 195-237.

Shwartz, M., G. Baker, K. P. Mulvey, A. Plough, 1997. "Improving Publicly Funded Substance Abuse Treatment: The Value of Case Management," *American Journal of Public Health*, 87(10): 1659-1664.

Siegal, H. A. and P. A. Cole. 1993. "Enhancing Criminal Justice Based Treatment Through the Application of the Intervention Approach." *Journal of Drug Issues* 23:131-142.

Siegal, H., R. C. Rapp, J. Fisher, P. Cole and J. H. Wagner. 1994. "Implementing Innovations in Drug Treatment: Case Management and Treatment Induction in the Enhanced Treatment Project." Pp. 131-143 in *Drug Abuse Treatment: The Implementation of Innovative Approaches*, edited by B. W. Fletcher, J. A. Inciardi and A. M. Horton. Westport, CT: Greenwood Press.

Siegert, F. A., & B. T. Yates. 1980. "Cost-Effectiveness of Individual In-Office, Individual In-Home, and Group Delivery Systems for Behavioral Child-Management." *Evaluation and the Health Professions*, 3:123-152.

Simpson, D. D. 1981. "Treatment for Drug Abuse: Follow-Up Outcomes and Length of Time Spent." *Archives General Psychiatry* 38:875-880.

Simpson, D. D., 1997. "Facts About Legal Offenders! Research Summary" Institute of Behavioral Research at Texas Christian University.

Simpson, D. D. 1998. "DATOS First-Wave Findings Released" Research Roundup, Vol 7(4):1-8. Institute of Behavioral Research at Texas Christian University.

Simpson, D. D. and S.B. Sells. 1982. "Effectiveness of Treatment for Drug Abuse: An Overview of the DARP Research Program." *Advances in Alcohol and Substance Abuse Treatment* 2:7-29.

Simpson, D. D., G.W. Joe, K. M. Broome, M. L Hiller, K. Knight, and G. A. Rowan-Szal. 1997a. "Program Diversity and Treatment Retention Rates in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11(4): 279-293.

Simpson, D. D. G. W. Joe, and B. S. Brown. 1997b. "Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)." *Psychology of Addictive Behaviors* 11(4): 294-307.

Sullivan, W. P., D. J. Hartmann, D. Dillon and J. L. Wolk. 1994. "Implementing Case Management in Alcohol and Drug Treatment." *Families in Society* 75:67-73.

Swartz, J. A., Lurigio, A. J., and Slomka, S. A. 1996. "The Impact of IMPACT: An Assessment of the Effectiveness of a Jail-Based Treatment Program." *Crime and Delinquency* 42:553-573.

Swartz, J.A., 1994. "TASC—The Next 20 Years: Extending, Refining, and Assessing the Model," in J. A. Inciardi. Drug Treatment and Criminal Justice. Sage Criminal Justice Systems Annuals (27): Sage Publications.

Taxman, F. S. 1991. "Substance Abuse Treatment within the Criminal Justice System: An Analysis of Conflicting Models and Implications for the Criminal Justice System." *Perspectives* , Summer.

Taxman, F.S., 1994. "Results from Focus Groups with Defenders," in *Cornerstone* Vol 16(2),Summer,. Washington, D.C.: National Legal Aid and Defenders Association

Taxman, F. S. and J. M. Byrne. 1994. "Locating Absconders: Results from a Randomized Field Experiment." *Federal Probation* 58:13-23.

Taxman, F.S., and D. Spinner, 1997. *Jail Addiction Services (JAS) Demonstration Project in Montgomery County, MD: Jail and Community Based Substance Abuse Treatment Program Model.* University of Maryland, College Park.

Taxman, F. S., D. Lockwood, and D. Perez, 1996. *Washington/Baltimore HIDTA Case Studies: Results from 15 Months of Developing Seamless Systems.* University of Maryland, College Park.

Tims, F. M., B. W. Fletcher and R. L. Hubbard. 1991. "Treatment Outcomes for Drug Abuse Clients." Pp. 93-113 in *Improving Drug Abuse Treatment*, edited by R. W. Pickens, C. G. Leukefeld and C. R. Schuster. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 106.

Tims, F. M. and J. Ludford (Eds.). 1984. *Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects.* Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 51.

Tonry, M. 1990. "Stated and Latent Functions of ISP." *Crime and Delinquency* 36:174-191.

Tonry, M. and R. Will. 1988. *Intermediate Sanctions.* Final Report to the National Institute of Justice. Castine, ME: Castine Research Corporation..

Visher, C. A. 1990. "Incorporating Drug Treatment in Criminal Sanctions." *NIJ Reports* 221:2-7.

Weinman, B. A. and D. Lockwood. 1993. "Inmate Drug Treatment Programming in the Federal Bureau of Prisons." Pp. 194-208 in *Drug Treatment and Criminal Justice*, edited by J. A. Inciardi. Newbury Park, CA: Sage Publications.

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

Wexler, H. K., G. P. Falkin, D. S. Lipton and A. B. Rosenblum. 1992. "Outcome Evaluation of a Prison Therapeutic Community for Substance Abuse Treatment." Pp. 156-175 in *Drug Abuse Treatment in Prisons and Jails*, edited by C. G. Leukefeld and F. M. Tims. Rockville, MD: National Institute on Drug Abuse Research Monograph Series, No. 118.

Wexler, H. K., D. S. Lipton and B. D. Johnson. 1988. *A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody.* Washington, DC, National Institute of Justice.

Williams, T and S. Spingarn, 1997. Personal Communication.

Washington/Baltimore HIDTA, 1997. *Annual Report to the Office of National Drug Control Policy.* University of Maryland, College Park.

Woodward, Bob, 1993. "Establishing and Maintaining the Policy Teams," in McGuarry, Peggy and M. Carter (eds) *Handbook for Policy Makers: Implementing Intermediate Sanctions.* National Institute of Corrections.