U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

National Institute of Justice

Research Report

The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision

Presentation at the 1995 conference
on criminal justice research
and evaluation

About the National Institute of Justice

The National Institute of Justice, a component of the Office of Justice Programs, is the research and development agency of the U.S. Department of Justice. NIJ was established to prevent and reduce crime and to improve the criminal justice system. Specific mandates established by Congress in the Omnibus Crime Control and Safe Streets Act of 1968, as amended, and the Anti-Drug Abuse Act of 1988 direct the National Institute of Justice to:

- *Sponsor special projects and research and development programs* that will improve and strengthen the criminal justice system and reduce or prevent crime.
- *Conduct national demonstration projects* that employ innovative or promising approaches for improving criminal justice.
- *Develop new technologies* to fight crime and improve criminal justice.
- *Evaluate the effectiveness of criminal justice programs* and identify programs that promise to be successful if continued or repeated.
- *Recommend actions* that can be taken by Federal, State, and local governments as well as private organizations to improve criminal justice.
- *Carry out research on criminal behavior.*
- *Develop new methods of crime prevention* and reduction of crime and delinquency.

The National Institute of Justice has a long history of accomplishments, including the following:

- Basic research on career criminals that led to development of special police and prosecutor units to deal with repeat offenders.
- Research that confirmed the link between drugs and crime.
- The research and development program that resulted in the creation of police body armor that has meant the difference between life and death to hundreds of police officers.
- Pioneering scientific advances such as the research and development of DNA analysis to positively identify suspects and eliminate the innocent from suspicion.
- The evaluation of innovative justice programs to determine what works, including drug enforcement, community policing, community anti-drug initiatives, prosecution of complex drug cases, drug testing throughout the criminal justice system, and user accountability programs.
- Creation of a corrections information-sharing system that enables State and local officials to exchange more efficient and cost-effective concepts and techniques for planning, financing, and constructing new prisons and jails.
- Operation of the world's largest criminal justice information clearinghouse, a resource used by State and local officials across the Nation and by criminal justice agencies in foreign countries.

The Institute Director, who is appointed by the President and confirmed by the Senate, establishes the Institute's objectives, guided by the priorities of the Office of Justice Programs, the Department of Justice and the needs of the criminal justice field. The Institute actively solicits the views of criminal justice professionals to identify their most critical problems. Dedicated to the priorities of Federal, State, and local criminal justice agencies, research and development at the National Institute of Justice continues to search for answers to what works and why in the Nation's war on drugs and crime.

The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision

Douglas S. Lipton

Presentation at the 1995 conference on criminal justice research and evaluation

November 1995

U.S. Department of Justice

Office of Justice Programs

National Institute of Justice

Jeremy Travis
Director

Christy Visher, Ph.D.
Program Manager

Douglas S. Lipton, Ph.D., is a Senior Research Fellow with the National Development and Research Institutes in New York.

This paper is an adaptation of the presentation Dr. Lipton made on July 11, 1995, at "What To Do About Crime," the annual conference on research and evaluation, sponsored by the National Institute of Justice, the Bureau of Justice Assistance, and the Office of Juvenile Justice and Delinquency Prevention and held in Washington, D.C.

NCJ 157642

Contents

Abstract

The proportion of people in the criminal justice system who are substance abusers is very high and has grown larger in recent years. Rehabilitation and treatment offered to prison inmates has had a checkered history in this country, however. This paper interweaves a number of themes related to these facts: the relationship of drugs to crime, the current overcrowded situation in correctional facilities, and state-of-the-art treatment approaches used with substance-abusing offenders who are in custody. The paper presents the findings of studies that have demonstrated that in-custody treatment, particularly the therapeutic community (TC) model, can be effective in preventing rearrest and in other outcomes. Moreover, with this approach, successful outcomes are positively related to the amount of time spent in treatment. Several successful projects—notably Stay'n Out, Cornerstone, Amity Prison TC, Key-Crest, KEEP, and TASC—are highlighted. The CDATE project, a 25-year update of the author's study of the effectiveness of correctional treatment, is also described.

The Relationship Between Drugs and Crime

A large number of people who abuse drugs come into contact with the criminal justice system when they are sent to jail or to other correctional facilities. In fact, the criminal justice system is flooded with substance abusers. The need for expanding drug abuse treatment for this group of people was recognized in the Crime Act of 1994, which for the first time provided substantial resources for Federal and State jurisdictions. Although drafting the Act required reconciling many disparate points of view, all parties agreed on the larger goal of crime reduction. Whether treating offenders is a worthwhile path to this end is in question, at least in the minds of some members of Congress, among others. This perspective is understandable, because treating offenders for substance abuse has had a checkered history in this country.

This paper argues that the time in which drug-using offenders are in custody presents a unique opportunity to provide them with treatment. Presented here are descriptions of several programs in operation throughout the country. The emphasis is on programs modeled on the therapeutic community (TC) approach. For most of the programs presented, evaluative research has been conducted or is under way. Where the research findings are available, they indicate great promise in reducing drug use and offender arrest rates.

Even before examining what lies behind the checkered history of treating offenders in this country, it is useful to understand why treatment is necessary for people under criminal justice supervision. Data from the Drug Use Forecasting program (DUF), which has been testing arrestees for the use of illicit drugs since 1987,[1] indicate that the proportion of substance abusers has never fallen below 60 percent and has been as high as 85 percent (Wish and O'Neil, 1989; National Institute of Justice, 1994). Among people who are incarcerated, the proportion of drug-using offenders is even higher (GAO, 1991; Prendergast, 1992). In many instances, these men and women

are typically users of many drugs—taking them in combination with each other and with alcohol. At least 45 percent of arrestees charged with violent crimes or income-generating crimes (such as robbery, burglary, and theft) in 1988 tested positive for use of one or more drugs (*NIJ Reports*, 1989). If they are chronic users, as one study has suggested (Johnson, 1986), their drug use pervades their lifestyle and preoccupies their day-to-day activities.

Most drug-using offenders have avoided treatment while active in the community, although some have experienced detoxification several times. According to one report (Lipton, 1989), more than 70 percent of active street addicts in New York City have never been in treatment nor intend to enter treatment for their addiction. The data are almost identical for Delaware's offender population (Peyton, 1994:9).

The Recent Increase in Drug-Abusing Offenders

Since the second half of the 1980's, there has been a marked growth in prison and jail populations, continuing a trend that began in the mid-1970's. The proportion of drug users in the incarcerated population grew over that time—by the end of the 1980's about one-third of those sent to State prisons had been convicted of drug offenses—the highest proportion in the country's history (Reuter, 1992).

With the advent of crack use in the mid-1980's, the already strong relationship between drugs and crime heightened. Cocaine use doubled in most cities and tripled in some, while the use of other drugs (notably heroin and PCP) declined or remained stable (Wish and O'Neil, 1989). Data from Miami (Inciardi, 1993) and observational and anecdotal reports from several cities in the Northeast (New York, Philadelphia, Baltimore, and Newark) indicate an increase and a leveling at high levels in heroin availability, purity, and use.[2] Data from DAWN[3] support these observations.

Crack-accelerated violence in the streets—particularly increasing numbers of apparently random acts of violence, gang activ-

ity, and shootings of innocent bystanders—has angered the public; consequently, citizen pressure on the police and the courts for action has increased. Levels of crack use have now been reported to be increasing in rural and suburban as well as urban areas. As a result, the number of inmates in State prisons who have histories of crack use has been increasing as well (Fagan et al., 1990).

Drug Use and Serious Crime

Overall, the U.S. prison population has grown about 60 percent in the past decade, an increase fueled largely by the influx of substance-abusing offenders. They are responsible for a relatively large amount of crime. Among them the most predatory—the heroin-using "violent predators"—committed 15 times more robberies, 20 times more burglaries, and 10 times more thefts than offenders who do not use drugs (Chaiken, 1986). Studies conducted among heroin users in Baltimore (Ball et al., 1983) and New York (Johnson, 1986) demonstrated that active drug use accelerates the users' crime rate by a factor of four to six and that the crimes committed while people are on drugs are at least as violent, or more so, than those committed by people who do not use drugs. Initial impressions from studies of crack-related crime indicate that the rate is as high or higher than heroin-related crime, and is certainly more violent.

Data vary from study to study, but it would appear that drug-using felons are also a primary source of failure on parole; that is, they constitute a disproportionate share of repeat offenders. Sixty to 75 percent of untreated parolees who have histories of heroin and/or cocaine use are reported to return to using these drugs within 3 months after release and to become reinvolved in criminal activity (Wexler et al., 1988). The "revolving door" analogy epitomizes the situation with offenders who use hard drugs.

Crime and severe drug abuse. The extensive research on the relationship between drug abuse and crime provides convincing evidence that a relatively few substance abusers who have a severe drug problem are responsible for an extraordinary proportion of crime (Gropper, 1985; based on the work of Johnson et

al., 1985; Ball et al., 1983; and Inciardi, 1979). Because of the seriousness of their crimes and their criminal records, many of these drug-abusing offenders are incarcerated. Without treatment, a high proportion will relapse into drug use after release from custody and return to crime. These behaviors are part of a lifestyle that is both highly destructive and resistant to change (Walters, 1992). About one-quarter of the drug users in prison were previously in treatment (Prendergast, 1992).

Current Availability of Treatment

Because a large proportion of drug users in this country are processed through some part of the criminal justice system during their substance-abusing careers, it makes a great deal of sense to consider the system as a location for treatment. Most inmates have not been treated in the community and, when asked, indicate they have no particular interest in entering treatment (Lipton, 1989). Thus, their entry into the criminal justice system presents a major opportunity to bring to bear the most recent advances in drug abuse treatment for this otherwise elusive population. A logical, cost-effective, and convenient point of intervention is the time they are in custody.

How Many Receive Treatment?

In 1979, there were 160 prison treatment programs serving about 10,000 inmates—4 percent of the Nation's prison population (NIDA, 1981). Of that number, 49 programs (32 percent) were based on the TC model and served about 4,200 participants (or 42 percent of all participants). Almost 10 years later, the percentage of prison inmates in drug treatment programs had risen to an estimated 11 percent (Chaiken, 1989).

Although the increase has been sizable (from 10,500 inmates in 1979 to 51,500 in 1987), the majority of inmates with substance abuse problems still do not receive treatment while in prison. According to one recent estimate (Prendergast, 1992), on the basis of data from the DUF sites, the number of drug-using arrestees who are probably in need of treatment exceeds 2 mil-

lion (980,000 need treatment for cocaine use, 280,000 for opiates, 27,000 for amphetamines, and 780,000 for injection drug use).

There is still no consensus about the percentage of offenders being treated for drug use. However, recent (though incomplete) surveys reveal that more than half the States offer either assessment procedures, education programs, counseling, other programs, or some combination (Frohling, 1989; GAO, 1991). (See table 1.) An optimistic assessment is that about 20 percent of identified drug-using offenders are served by these programs (Frohling, 1989; GAO, 1991).

Table 1: **Types of State Drug Treatment Programs for Offenders**

Program	Number of States
Assessment procedure for newly sentenced inmates	39
Narcotics Anonymous, Cocaine Anonymous, or Alcoholics Anonymous group meetings	44
Short-term (35–50 hours) drug education	44
Counseling for individuals	31
Group counseling	36
Intensive residential program	30

REFORM and RECOVERY—Federal Catalysts for State Action

Some 22 States were aided in their efforts to begin or expand comprehensive, statewide drug treatment through Project REFORM (funded by the Bureau of Justice Assistance of the U.S. Department of Justice) and Project RECOVERY (now funded by the Center for Substance Abuse Treatment, U.S. Department of Health and Human Services).[4]

As a result of Project REFORM, the following drug abuse treatment system components were established:

• 39 assessment and referral programs implemented and 33 expanded or improved.

• 36 drug education programs implemented and 82 expanded or improved.

• 44 drug resource centers established and 27 expanded or improved.

• 20 in-prison 12-step programs implemented and 62 expanded or improved.

• 11 urine monitoring programs expanded and 4 expanded or improved.

• 74 prerelease counseling and/or referral programs implemented and 54 expanded or improved.

• 39 postrelease treatment programs with parole or work release implemented and 10 expanded or improved.

• 77 isolated-unit ("milieu") treatment programs initiated and/or improved (16 brief [less than 6 weeks] programs, 19 short-term [6–12 weeks] programs, 34 intermediate [5–9 months] programs, and 8 long-term [9–15 months] treatment programs).

The Impact of REFORM

Project REFORM laid the groundwork for the development of effective prison-based treatment for incarcerated drug abusers. It also had indirect effects on the correctional systems of the participating States (and those of other, nonparticipating systems)—effects not easily assessed but nonetheless real. Presentations were made at professional conferences to national groups and policymakers and to local correctional officials (e.g., wardens, prison administrators) concerning REFORM, the principles of effective correctional change, and the efficacy of prison-based treatment. Information was presented on the day-to-day benefits of involving inmates in treatment: decreases in drug use, violence, and other antisocial behaviors during incarceration. It is likely that these presentations increased the receptivity of local and State correctional officials to implementing drug and alcohol abuse treatment programs in their facilities.

Perhaps most important was the catalytic effect of REFORM on the correctional community in general. Since the mid-1970's, the field of State corrections had shifted ideologically toward "just deserts," with rehabilitation as a function and purpose of corrections diminishing markedly. The combined effect of workshops, consultants' visits, the attendance of nonparticipating States at the workshops, testimony and written presentations by REFORM's national coordinators and correctional leadership before Congressional committees and State hearings, as well as at major meetings of various national organizations generated interest within the correctional community. Other States, and even other countries, began seeking information about how to organize and initiate drug abuse treatment programming for their correctional inmates.

Correctional officials have made clear that the comprehensive plans developed as a result of Project REFORM were useful and that the process helped State officials assess problems related to the provision of drug and alcohol abuse

services within their correctional system. The plans also helped them develop appropriate short- and long-range strategies for service enhancement.

New service delivery models were created that enhanced continuity of treatment so that programming begun in a given institution could continue after participants were released into the community. These models included ways of developing contracts with community programs to provide counseling and treatment planning assistance to offenders who were approaching their release date and providing residential and out-patient treatment after discharge and/or parole to the community.

RECOVERY Follows

The focus shifted in 1991 to the new Center for Substance Abuse Treatment (formerly known as the Office for Treatment Improvement), which established Project RECOVERY. RECOVERY provided technical assistance and training services to pilot prison drug treatment programs and continued the work begun by REFORM. Most of the States that originally participated in REFORM became involved in RECOVERY, and an additional seven States that had completed comprehensive correctional treatment plans were added (*Infra*, p. 19).[5]

Federal Assistance

The States were assisted in their efforts to begin or expand comprehensive programs through two Federal Government initiatives, projects REFORM and RECOVERY. Begun in 1987, Project REFORM laid the groundwork for the development of prison-based treatment for incarcerated drug abusers and, perhaps most important, had a catalytic effect on the correctional community in general, promoting corrections officials to shift in their thinking toward rehabilitation, a concept that had been in abeyance for some time. Project RECOVERY, launched in 1991, followed REFORM in providing technical assistance and training to pilot programs.

Rising Prison Population Drives the Need

Last year the Nation's prison population passed the 1 million mark, and the total number of adults in the criminal justice system now approaches 5 million (BJS, 1994). This is the largest number ever under the control of criminal justice authorities. The prison population alone increased two and one-half times between 1980 and 1993. The vast majority (more than 80 percent) are recidivists, and about three in four previously used drugs. The number of prisoners in the custody of State correctional authorities for drug offenses increased ninefold (from 19,000 to 172,300) between 1980 and 1992 (Beck and Gilliard [BJS], 1995).

Many of these prisoners have severe substance abuse problems. Indeed, about one-third of the inmates previously used a major drug (heroin, methadone, cocaine, LSD, and PCP) on a regular basis and more than half reported using drugs during the month before the crime for which they were incarcerated. Slightly more than half say they were under the influence of alcohol or drugs at the time of the offense for which they were incarcerated.

Some of these inmates are predatory criminals with severe substance abuse problems; they are responsible for an extraordinary amount of crime and are involved in a variety of violent crimes, property offenses, and drug deals. These facts make it clear that in order to improve the quality of life and ensure public safety, it is imperative to find ways to prevent their relapse into drug use and to significantly reduce recidivism.

Other Priorities May Take Precedence

It is evident, however, that senior State-level correctional executives have another overriding concern: ensuring adequate space to house inmates. Their budgets reflect that priority: additional prison space takes priority over rehabilitation programs. It is also clear that some correctional officials are in conflict as to *where* to treat offenders; that is, they need to determine whether resources should be allocated to community-based or prison-based programs.

Some prison administrators believe that prison-based treatment programs make it more difficult to manage inmate housing. Problems occur when a facility is overcrowded and, in an attempt to separate program residents from general population inmates, a separate housing unit has been dedicated to a treatment program. This sometimes leads to filling unused treatment space with inappropriate inmates.

Legislators, as well as correctional authorities, are often skeptical about the effectiveness of correctional treatment and reluctant to spend tax dollars on efforts that net no votes and are likely, in their minds, to produce little change in behavior.

Despite these objections, correctional authorities evidently recognize that one major benefit of prison-based drug treatment programs is enhanced security in the institution. Drug use and drug dealing (rampant in some prisons) decline with the introduction of drug treatment programs and random urinalysis (Vigdal and Stadler, 1989). Infractions of prison rules as well as violence and threats of violence also decline, as does the threat of prison riots. Also, the pernicious influence of gangs within correctional facilities diminishes as effective programming

increases. For these reasons, correctional authorities have assigned drug treatment a higher priority during the past decade. As a result, between 1979 and 1990 the percentage of inmates receiving some form of treatment more than tripled (Lipton et al., 1992).

Public Support

Many policymakers, especially legislators, oppose funding for prison-based drug treatment programs because they believe that the public wants offenders punished and that treatment programs coddle criminals. Although it is true that Americans want criminals punished and that public support for rehabilitation has declined substantially since the late 1960's, there is evidence that "support for rehabilitation remains surprisingly strong" (Cullen and Gendreau, 1988).

An example from the State of Michigan illustrates this support. A survey conducted there revealed that 12 percent of policymakers in Michigan *assumed* that citizens favored prison rehabilitation. In fact, fully 66 percent of the public believed rehabilitation should be a primary goal of prisons (cited in Cullen and Gendreau, 1988). This is not an isolated finding; several other nationwide and State surveys reveal that the public continues to support prison rehabilitation. According to another study, citizens want "assurances of safety much more than they want assurances of punishment," and they "want prisons to promote rehabilitation as a long-term means of controlling crime" (Public Agenda Foundation, 1987: 5; cited in Cullen and Gendreau, 1988). Surveys completed in the summer of 1995 continue to indicate support on the part of the public for prison rehabilitation (H. Kleber, personal conversation, 1995).

Evolution of Prison-Based Treatment

Treatment for incarcerated Federal offenders formally began with the opening of two U.S. Public Health Service hospitals, one in Lexington, Kentucky, in 1935 and one in Fort Worth, Texas, in 1938. The need for these facilities was first recognized by the then-Director of the Federal Bureau of Prisons, who urged Congress to establish "Narcotic Farms" in these locations. These facilities evolved from farms to hospitals to clinical research centers, were transferred from the U.S. Public Health Service, and are now part of the Federal prison system.

Drug abuse treatment in prisons has been influenced by the development of therapeutic communities, which in their prison manifestation often place recovered drug users in a therapeutic environment isolated from the general prison population. Before 1980, relatively few evaluative research studies of therapeutic communities in prison settings had been conducted. Recently published findings regarding New York's Stay'n Out program (Wexler, Lipton, and Falkin, 1989, 1990), Oregon's Cornerstone Program (Field, 1984, 1989), Delaware's Key-Crest programs (Inciardi, 1995), and California's Amity Prison TC program (Wexler, 1995), and unpublished preliminary findings of a study of the New Vision program in Kyle, Texas (Simpson and Knight, 1995), substantiate the significant accomplishments of correctional-based therapeutic communities with incarcerated drug-abusing felons.

The "Nothing Works" Era

As noted above, however, prison drug abuse treatment, along with treatment for non-drug abusers, is currently limited, and over the past 20 years the field of corrections is noteworthy for its failure to pursue rehabilitative goals. I am responsible, in part, for this situation. The cynical notion that "nothing works" emerged from a summary (Martinson, 1974) of a study I conducted in collaboration with two colleagues and published in 1975 (Lipton, Martinson, and Wilks, 1975).

The summary appeared at a time when the national media and the social climate were ripe for a shift away from the so-called "rehabilitative era." Liberals and conservatives alike felt that, as James Q. Wilson put it at the time, ". . .belief in rehabilitation requires not merely optimistic but heroic assumptions about the nature of man" (1975: 192).

As I suggested later (Lipton, 1994), the anti-rehabilitation backlash grew out of the scientific corroboration that opponents of rehabilitation were able to match with their deeply held beliefs regarding punishment, "just deserts," and general deterrence. They found that corroboration in the summary, which proved to be highly influential. "With few and isolated exceptions," the article concluded, "rehabilitative efforts that have been reported so far have no appreciable effect on recidivism" (1974: 25).

The phrase "nothing works" became a watchword and entered the corrections vocabulary; it was treated as fact. The belief that "nothing works" still enjoys widespread acceptance and is one of the main reasons drug treatment programs are given low priority despite high recidivism rates, especially among drug-abusing offenders.

The summary article was a more widely read popularization of a scholarly assessment of the outcomes of 30 years of rehabilitation efforts for criminal offenders—a project I directed and in which Robert Martinson, who wrote the summary, participated. The basic conclusion of our study *The Effectiveness of Correctional Treatment* was that "the field of corrections has not as yet found satisfactory ways to reduce recidivism by significant amounts" (Lipton et al., 1975: 627). Other authors who reviewed evaluation studies of rehabilitation programs came to essentially the same conclusion (Kirby, 1954; Bailey, 1966; Logan, 1972).

However, few people who espoused the view that nothing works questioned the validity of the research on which it was based or understood the problems inherent in the design of most treatment programs and in the methodologies used to evaluate them. They also did not recognize the difference between the pessimistic viewpoint of the summary article and the more guarded conclusion, arrived at by my colleagues and me, which left open the possibility that rehabilitation could work.

The Shift Toward Rehabilitation

So influential were research findings in the policy debate about sentencing reform and rehabilitation that they became the subject of a scholarly assessment by the National Academy of Sciences. In a report on the rehabilitation of criminal offenders, the Academy tempered the assessment that nothing works. It stated that "we do not now know of any program or method of rehabilitation that could be guaranteed to reduce the criminal activity of released offenders" (Sechrest et al., 1979: 3). It raised the question of whether some programs might work for certain types of offenders.

Since that time, a growing body of evaluation studies has come under careful scrutiny, and several authors have concluded that certain rehabilitation programs effectively reduce recidivism (Andrews et al., 1990; Gendreau and Ross, 1979, 1983–84, 1987; Greenwood and Zimring, 1985; Izzo and Ross, 1990; Lipsey, 1989, 1991; Lipton, 1992, 1994; Palmer, 1975; Wexler and Lipton, 1988, 1990; Van Voorhis, 1987). Some, however, are still pessimistic (Lab and Whitehead, 1988; Rosenbaum, 1988; Whitehead and Lab, 1989).

Ironically, a few years after publication of the summary "nothing works" article, the author revised his conclusion on the basis of further review of the research. His review revealed that "some treatment programs do have an appreciable effect on recidivism" (Martinson, 1979: 244). Two other scholars have since offered a trenchant critique, stating their belief that "the doctrine of nothing works is best seen as a socially constructed reality [rather than] an established scientific truth" (Cullen and Gendreau, 1989).

Persistence of the Anti-Rehabilitation Position

The critique notwithstanding, the generalized belief that nothing works has been a major factor in the reluctance of many policymakers to support prison-based drug treatment.

Policymakers who espouse this view usually believe that the public wants offenders punished and that supporting treatment would be a show of leniency. This belief is buttressed by the

argument that incarceration is the most—perhaps the only—effective means of controlling crime. Imprisonment, it is asserted, will keep criminals off the streets (the incapacitation argument) and prevent them from recidivating (the individual deterrence argument), whereas others will refrain from committing crime out of fear of the consequences (the general deterrence argument).

Because longer and more certain sentences have led to increases in prison populations, because significantly more public attention has been paid to the "drug problem," and because court orders have limited overcrowding, more prisons have been built and cells added in the years since the publication of *The Effectiveness of Correctional Treatment* than ever before, and there are no vacant cells (Reuter, 1992). As noted above, the proportion of drug users in the incarcerated population increased in that period, so that by 1988 about one-third of those sent to State prisons had been convicted of drug offenses—the highest proportion in history (Reuter, 1992). No new treatment programs were established, and existing treatment and rehabilitation programs were terminated (Murray, 1992). In jails, treatment for drug abusers is even more limited than in prison (although this is to be expected given the brief length of stay) (Peters and May, 1992).

The current reemphasis on providing drug abuse treatment in prisons and jails appears to be anchored in the need to do something about the large numbers of drug abusers who are incarcerated. The reemphasis is also driven by recent research findings that reveal the effectiveness of drug abuse treatment (Hubbard, Marsden, Rachel, Cavanaugh, and Ginzburg, 1989; and Gerstein and Harwood, 1992).

Varying Perspectives on Effectiveness of Treatment

Effectiveness is related specifically to the length of time an individual remains in treatment, regardless of the type of treatment provided. However, it should be kept in mind that once a person is addicted, the condition is chronic and the substance abuser is

prone to relapse. These two aspects of drug abuse often make the effectiveness of drug abuse treatment difficult for many to understand. Viewed from a health perspective, treatment should be followed by a "cure," with no further drug abuse.

Viewed from the perspective of the legislator and the lay public, the outcome of treatment should be reduced recidivism (that is, a reduced tendency to return to criminal behavior), together with elimination of or substantial reduction of drug abuse. In the field of corrections, the health goals and the criminal justice goals are compatible but are not frequently implemented coherently. This often gives rise to tension, though as an unintended consequence.

Legislators and the public also appear to suspect that drug abuse treatment is futile despite research findings, which have consistently indicated it is effective (Hubbard, Marsden, Rachel, Cavanaugh, and Ginzburg, 1989), especially when combined with criminal justice sanctions (Leukefeld and Tims, 1986). This suspicion underlies some of the reluctance to establish treatment programs. When pressed, correctional administrators indicate they want these programs, although not as much in the hope of producing salutary change as to keep inmates actively involved during their incarceration.

Experiences related to treating drug abusers in prisons and jails are drawn largely from this country. Unfortunately, these experiences are closely related to the rapid expansion of drug use in the major urban areas of this country and the associated crime, most recently crime related to crack cocaine. These "epidemics" strain the resources of both correctional facilities and community treatment settings. They have, however, given rise to the current recognition of the expanding drug abuse problem and thus opened for criminal justice practitioners a window of opportunity to establish drug abuse treatment interventions that are documented with research data and supported by practice.

In fact, criminal justice practitioners are recognizing the important control function that drug abuse treatment can exert in an institution. This function becomes in some cases a major purpose of the program and in others an "extra bonus." The impor-

tance of the control function becomes evident when we recognize that today all but eight States are under court order for prison overcrowding and that the more than 100 percent growth rate in the prison population during the past 10 years is very much the result of the huge influx of drug offenders.

Jail Treatment Programs

A survey conducted in 1992 revealed that only 28 percent of the Nation's jails offer drug abuse treatment, and only 19 percent fund drug treatment programs.[6] Of the drug treatment programs, 12 percent were isolated from the general jail population. The survey also revealed detailed information about the types of prisoners served, staffing, and program size. It indicated that the average jail drug treatment program focused on whites (who constitute 66 percent of program participants), and the average age of the participants was 26. The average number of inmates served in a program was 42, and the staff size was 3. More than 80 percent of the programs operated with volunteer staff.

The researchers calculated that only 6.7 percent of the people in the Nation's jails are enrolled in drug treatment and concluded that the need for treatment was acute. They felt the need can be met by developing links with community drug abuse treatment programs. The latest figures indicate that the U.S. jail population count is about 500,000, of whom about 102,000 are in substance abuse treatment or education programs (imputed, Beck and Gilliard, 1995).

Types of Treatment Models for Correctional Settings

Treatment for drug abusers in correctional settings is expressed in five ways:

• No specialized services (the most typical).

• Drug education and/or drug abuse counseling.

• Residential units dedicated to drug abuse treatment.

• Client-initiated and/or maintained services (self-help groups).

• Specialized services for drug abusers that are not directly targeted at the drug problems.

Additionally, three treatment models that serve as alternatives to incarceration have been identified:

• Probation, with a mix of counseling, support, and surveillance (the most typical).

• Surveillance, components of which include house arrest, electronic monitoring, and urinalysis.

• Diversion, which is represented by the TASC (Treatment Alternatives to Street Crime) program.

These typical treatments, whether for people who are incarcerated or people under community supervision, can take many forms, can be on a large or small scale, and can take place in a variety of settings (Brown, 1992).

The Federal Prison System Program

In the Federal Bureau of Prisons (BOP), providing treatment to drug abusers has been spotty and slow in coming, although nearly 61 percent of its 88,000 inmates were incarcerated for drug-related crime (Hawk, 1995). (When examining this high percentage, it is important to keep in mind that, according to a 1993 analysis, 21 percent of the inmates were "low-level" drug law violators; that is, they had no current or prior convictions for violence, no record of sophisticated criminal activity, and no prior commitment of offenses.)

In about the past 10 years, the number of inmates in Federal prison has risen from 35,800 to almost 99,000. This increase has been fueled by several factors, not the least of which is the growing number of drug offenders (their proportion has risen from 30 percent in 1984 to more than 60 percent at present). In 10 years the average length of stay of drug offenders has also increased, from less than 2 years to more than 5.

Recent Increase in Treatment Programs

Ten years ago, drug abuse programming of all kinds served less than 4,200 inmates. Now, mainly as a result of the initiatives of the current BOP Director, Kathleen M. Hawk, programming has increased markedly. Now, the 30 percent of prisoners with moderate to severe drug use problems are treated in 34 residential therapeutic communities, and those with less severe problems are treated in nonresidential programs providing individual counseling and group therapy, special seminars, and aftercare. It is also important to note that the BOP now provides for continuity of treatment (transitional treatment and relapse prevention) when inmates are released either to supervision or to a halfway house.

The BOP's Comprehensive Approach

The Bureau has developed a comprehensive drug abuse treatment strategy, which includes a multitiered approach as well as a comprehensive evaluation. The approach includes one level of

drug education, three treatment levels, and one level of transitional services. The elements are as follows:

• Mandatory drug education programs for inmates with a substance abuse history.

• Individual, group, and self-help drug abuse counseling services, available on an outpatient basis to volunteers.

• Comprehensive residential drug treatment units, five of which began operating in fall 1990.

• Three pilot drug abuse treatment programs with a research emphasis, which became operational early in 1991.

• Transitional services for community reentry after release from comprehensive and pilot residential programs.

The BOP Program Under Study

The BOP's drug abuse treatment program was the subject of an evaluative study, whose preliminary results are soon to be released (Pellissier and McCarthy, 1992). The study focus was residential treatment and several sites were examined. Inmates were divided into four groups for study purposes. One group was randomly assigned to a high-intensity pilot program; another, a comparison group, received no further in-prison treatment; still another comparison group received moderate-intensity residential treatment; and the final group was a nonvolunteer comparison group.

The study measured inmates' socio-demographic characteristics; such cognitive attributes as psychological impairment, motivation, and cognition regarding substance abuse; treatment structure and process; and the post-release environment. The researchers examined the effect of the study on such short-term outcomes as prisoner "adjustment" (including rule infractions, urine that tested positive for drugs, and participation in institutional programs) and perceptions of drug use. The long-term outcomes the researchers examined included inmates' drug use and criminal activities, recidivism, social and occupational functioning, and mental/physical health.

Drug Treatment in State Correctional Facilities

New York's Stay'n Out Program

In enacting its "Omnibus Prison Bill" in 1989, the New York legislature adopted a coordinated approach to treatment. The new law provided $1 billion (from both tax levy and Federal block grant funds) for an approach emphasizing treatment. A 750-bed alcohol and substance abuse treatment facility and seven 200-bed substance abuse annexes are the core of the expansion. These Comprehensive Alcohol and Substance Abuse Treatment (CASAT) facilities use outside contractors to provide drug treatment to inmates who are within 2 years of parole eligibility, and they will guarantee participating inmates a place in their noncorrectional treatment facilities upon release. The bill also provides $500,000 to train as many as an additional 300 counselors who will serve as part of intensified drug treatment programs.

The Stay'n Out model. The model on which New York's program is based is the Stay'n Out program. Stay'n Out is a therapeutic community program that was established in New York in 1977 by a group of recovered addicts who were also ex-offenders (Wexler, Lipton et al., 1992). The program was evaluated in a study of about 2,000 program participants, begun in 1984.[7] The researchers reported that this prison-based therapeutic community treatment, which was provided by an outside contractor, New York Therapeutic Communities, Inc. (staffed by the group of ex-addict ex-offenders and using a modified Phoenix House model), reduced recidivism (rearrest) for both males and females.

The "time-in-program" hypothesis. The rationale for establishing the "Stay'n Out" prison TC was the findings of research on TC's based in the community. An important finding was that successful outcomes (measured in terms of reduced crime and substance use and increased employment) were related to the

amount of time spent in treatment (DeLeon et al., 1979; Simpson, 1979, 1980). In fact, residents who were sent to the program by the courts had a higher success rate than did volunteers. However, the community TC's produced excessively high dropout rates, which limited their effectiveness to the relatively few clients who remained at least 3 months in the program (DeLeon, 1979).

One of the justifications for establishing the Stay'n Out program was to test the efficacy of the "time-in-program" variable in an environment—prison—where residents were likely to stay far longer than 3 months. It was expected that inmates would find the isolated program unit (which shielded them from the general prison population) considerably more desirable than regular prison units. Thus, the major objectives of the evaluation were to evaluate the effectiveness of prison-based TC treatment and assess the "time-in-program" hypothesis.

Inmates in the Stay'n Out group were studied along with two types of comparison groups: inmates who volunteered for the TC program but who for various administrative reasons never participated (the "no-treatment controls") and inmates similar to those in Stay'n Out but who participated in other types of prison-based drug use treatment programs (counseling and milieu therapy) elsewhere in the prison system (Wexler, Falkin, and Lipton, 1990). (In analyzing the effects of the program over time, the treatment comparison groups help control for self-selection factors.)

Parole results. One measure analyzed by the evaluation was success or failure on parole. The information about parole was obtained from the records of 1,626 male and 398 female inmates in the State prisons. The treatment groups included all program clients who left the program through February 1984. The male and female no-treatment comparison groups comprised inmates who had volunteered for the therapeutic community program, were placed on waiting lists, but never entered the program because they could not meet the time eligibility criteria or for other administrative reasons. In other words, they were not dropouts.

The 435 members of the Stay'n Out male TC treatment group and the 247 members of the Stay'n Out female TC group were compared to no-treatment control groups and other-treatment groups. The male TC treatment group was compared to 159 members of no-treatment control groups that consisted of inmates who were on a waiting list for the program. These controls met all the criteria for admission except parole time eligibility and therefore completed their prison term without treatment.

The male TC group was also compared to a 576-member milieu treatment group, which was a residential treatment program offering less intensive treatment than the TC. (In the milieu treatment group, time was less structured than in the TC, there was no hierarchy of jobs or social roles, counselors were not ex-addicts or ex-offenders but were trained correctional officers, good conduct in the program was not rewarded with greater responsibility, and interaction with community TC's was less extensive.) Additionally, the male TC group was compared to a 261-member group that received individual and group counseling once a week.

The female TC group was compared to a 38-member control group that received no treatment and a 113-member group that received counseling. These female groups were similar to their male counterparts; that is, the control groups met the basic criteria for admission but did not receive treatment, and the alternative treatment group received only counseling services.

In background characteristics, the samples were comparable except that the male milieu group had a significantly higher mean age and criminal history score (a weighted average of prior criminal arrests, convictions, and sentences) and spent more time in prison than the other male groups. Certain statistical analyses were performed to control for the possible confounding effects of these differences on treatment outcomes.

The samples of inmates were selected from those released from prison between 1977 and 1984. The followup period, which ended in 1986, therefore ranged from 2 years to 9 years, depending on the year of release.

The groups were compared on several recidivism measures: the percentage arrested, the mean number of months until arrest, the percentage successfully discharged from parole, and the percentage not reincarcerated. In looking at arrests, the researchers found that at 27 percent, the rate for male TC treatment group was significantly lower than for all the other male groups. The arrest rate for the male TC group was significantly lower than for the male group in milieu therapy (35 percent), the male group that received counseling (40 percent), and the male group that received no treatment. (See table 2.) The male counseling group's arrest rate did not differ from that of the male group that received no treatment. Thus, the data provided support for the study hypotheses, with the TC treatment group showing the best results, followed by the group receiving milieu therapy treatment, the group receiving counseling, and, lastly, the group receiving no treatment (Wexler, Falkin, and Lipton, 1990).

Table 2: **Stay'n Out Program**
Arrest Rates of TC Participants Were Lower

Group	TC	Milieu Therapy	Counseling	No Treatment
Arrest Rate Males	26.9%	34.6%	39.8%	40.9%
Arrest Rate Females	17.8%	(This type of treatment not offered)	29.2%	23.7%

Most impressive, however, were the time-in-program effects. There is a strong positive relationship between number of months in the program and the percentage of people positively (that is, successfully) discharged from parole for the male TC group who were in treatment for up to 12 months. The percentage of male TC positive parole discharges increased from 49 percent for those in treatment less than 3 months to 58 percent for those in treatment 3 to 6 months, to 62 percent for those in treatment for 6 to 9 months, to a peak of 77 percent for those in TC 9 to 12 months. (See table 3.) The percentage then decreased to 57 percent for those in the program more than 12 months (Wexler, Falkin, and Lipton, 1990). Another significant finding was that the members of the male TC treatment group who sub-

sequently failed on parole stayed drug- and crime-free for significantly longer periods than the comparison groups.

Similar arrest results were found among the females, with the TC group having a significantly lower arrest rate than that for the combined counseling and no-treatment groups. (See table 2.) Comparisons reveal that at 17.8 percent, the female TC's arrest rate was significantly lower than that of the counseling group, whose arrest rate was 33 percent. But the differences between the no-treatment group and the counseling and TC groups were not statistically significant. In fact, the no-treatment group had a lower recidivism rate than the counseling group (Wexler, Falkin and Lipton, 1990). Thus, the findings for female inmates indicate that the TC was effective in reducing recidivism rates, but counseling showed no such effect.

With respect to parole, the time-in-program data for females are similar to those for males: an increase in positive parole outcomes, from 79 percent for those in treatment less than 3 months to a peak of 92 percent for those spending 9 to 12 months in treatment. (See table 3.)

Table 3: **Stay'n Out Program**
Favorable Outcomes for Parolees Increase as Amount of Time in Program Increases

	Less Than 3 Months	3–6 Months	6–9 Months	9–12 Months	More Than 12 Months
Males	49.2%	58.0%	62.0%	77.3%	57.0%
Females	79.0%	NA	NA	92.0%	77.0%

The robust central conclusion of the Stay'n Out evaluation is that hard-core drug abusers who remain in the prison-based therapeutic community longer are considerably more likely to succeed than those who leave earlier, and that 9 to 12 months appears to be the optimal duration for the treatment. As time in therapeutic community treatment increases, recidivism declines

significantly. The Stay'n Out evaluation, like other therapeutic community evaluative research, consistently found statistically significant and salient effects of time-in-program on treatment outcomes.

Moreover, the fact that male and female Stay'n Out clients do better on parole if they remain in the program 9 to 12 months rather than terminating earlier (or later) appears to be borne out in other studies as well and that similar lengths of time spent in the comparison modalities do not produce equally positive effects. This pattern was found to be consistent for the other outcome variables other than recidivism as well. It leads confidently to the conclusion that Stay'n Out is more effective than no treatment and alternative treatments and is especially effective when clients remain in treatment for an optimal period—9 to 12 months.

For those who failed on parole (that is, were rearrested), spending more time in therapeutic community treatment also tended to produce positive outcomes. When the researchers compared mean time until arrest for the two periods until program termination, they found that clients who received treatment for a shorter time were arrested much sooner than those who stayed in the program 9 to 12 months.

New York City's KEEP

The Key Extended Entry Program (KEEP) is a unique criminal justice-based treatment program using methadone maintenance (Magura, Rosenbaum, and Joseph, 1992). The program was established in 1987 on Rikers Island in New York City to provide methadone maintenance to heroin addicts charged with misdemeanors and referral to community methadone programs with dedicated treatment slots. KEEP was also designed to provide methadone maintenance to prisoners already in MMTPs (methadone maintenance treatment programs) to ensure some program continuity (that is, in the pharmacologic component).

A long-term followup study of 225 program participants and controls revealed that KEEP participants were daily heroin and cocaine users, more than half of the injectors (54 percent) re-

ported sharing needles or works in the previous 6 months, and property crimes were their most frequent arrest charge. For those not in methadone treatment when released to community treatment, the attrition rate (rate of return to substance abuse) was high—60 percent for men and 67 percent for women. For those who were already methadone patients when they were incarcerated, the attrition rate was much lower (Magura et al., 1992).

Florida's Four-Tiered Approach

The Florida Department of Corrections, more than half of whose inmates admit to a serious substance abuse problem, has established a four-tiered approach as part of its comprehensive statewide strategy (Bell, Mitchell, Williams, Benvino, and Darabi, 1992). The program starts with an assessment of the severity of substance abuse and a recommendation for a treatment level. The four tiers of the program are as follows:

• Tier I—a 40-hour program focused on providing educational drug abuse information for inmates identified as having a less-than-severe substance abuse history, who deny having a problem, and whose sentences are brief.

• Tier II—an intensive, 8-week residential modified therapeutic community program for inmates diagnosed with a severe drug problem.

• Tier III—residential therapeutic community treatment, provided for 9 to 12 months in the community through contract services, to inmates who meet work release requirements. The number of beds available is 54.

• Tier IV—10 weeks of community counseling focused on relapse prevention and supportive therapy for inmates assigned to Community Correctional Centers.

Now under way is an evaluative study of the program process, focused on program "integrity," and an outcome evaluation aimed at assessing changes in inmate knowledge, attitudes, and behaviors.

New Jersey—Wharton Tract Narcotics Treatment Program

Among the drug treatment programs the State of New Jersey has established for its prison inmates, the Wharton Tract Narcotics Treatment program, in operation since 1970, is particularly notable. (See description in Platt et al., 1980.) A satellite unit of the Youth Reception and Correction Center in Yardville, New Jersey, the program housed 45 youthful offenders (over 19 years of age) in a former State forestry camp situated in Wharton State Forest. Offenders were admitted if they met the following criteria: had 8 to 12 months of incarceration remaining in their sentence, had been dependent on heroin more than 6 months but less than 5 years, exhibited no extreme psychopathology, had no recent escapes, and had no serious pending offense.

The program was based on the therapeutic community model and included "Guided Group Interaction" (GGI), which holds that development of a group enhances the recovery of its members through a process of interaction. Also included was the technique of "Interpersonal Problem-Solving Group Therapy." This involved development of problem-solving skills (e.g., identification of a problem and the feelings associated with it, acquiring information, searching for possible solutions, and assessing consequences) through a series of group exercises. The program also offered couples therapy, family counseling, individual counseling, and recreational activities.

Residents completed the program in three phases: a 30-day evaluation period, intensive therapy (lasting at least 60 days), and a transition phase of several months to ease residents back into the community.

An evaluative study revealed that program graduates did better in avoiding recommitment after parole and remaining arrest-free. A group of 160 program graduates was compared with a group of 148 control subjects who had met all the criteria for admission but did not enter treatment (Platt et al., 1980). There were no significant differences between the background characteristics of the two groups.

A 2-year followup revealed that the rate at which the control group was recommitted was significantly higher following parole than the rate of the group that graduated from the program (30 percent and 18 percent, respectively).[8] What is more, the proportion of graduates who remained arrest-free was significantly higher than in the control group (51 percent and 34 percent, respectively).

The Texas Initiative

The "Texas Initiative" in correctional substance abuse treatment started by then-Governor Ann Richards was enormous and complex. For 4 years the planned initiative was developing into the most ambitious and aggressive prison-based drug and alcohol treatment system ever established in the country. Since then, however, program development has halted, although prison construction proceeds apace.

The State's prison population is now approaching 120,000, with 80 to 90 percent said to have serious alcohol and drug abuse problems. Provision of treatment for substance abusers, however, is regressing, having been cut in half—from 1,600 beds to 800. It should be noted that this apparent shift was not merely a product of a new political orientation but a reasoned and prudent response to an impassioned but too hasty approach to the problems of drug offenders in the Texas system.

Provisions of the law. The landmark law that launched the Texas Initiative was enacted in 1991 and provided the statutory foundation for developing a comprehensive treatment system for substance-abusing offenders. Though now vastly scaled back, it still represents the largest such effort ever attempted in this country. The legislation established the following three criminal justice substance abuse initiatives:

• Treatment Alternatives to Incarceration Program (TAIP). Under TAIP, offenders in the six largest counties in Texas were to be screened and assessed for chemical dependency problems and referred for appropriate community-based chemical dependency treatment. Funding for treatment for those referred by the

screening and referral system was also augmented by the legislation. The Senate version of the law required full implementation of the program in the six counties by the end of fiscal year 1992. The year after the law was passed, the legislature recommended expanding the TAIP program to the next seven most populous counties.

• Substance Abuse Felony Punishment (SAFP) System. In this program, offenders convicted of nonviolent felonies who had crime-related substance abuse problems could, as a condition of probation or parole, receive 6 to 12 months of long-term substance abuse treatment in SAFP facilities. Clients who completed primary treatment in SAFP facilities were then assimilated back into the community through a 15-month continuum of care that incorporated a support system of decreasing intensity and structure. The primary components of the continuum of care in the community consisted of Transition Treatment Centers (TTC) that were to provide residential and nonresidential supportive services; a transition team whose membership included a TTC representative, representatives of probation or parole, the client and the client's spouse or other partner; and peer support and peer networking groups.

As originally enacted, the legislation authorized the acquisition and construction of 12,000 secure treatment beds for the SAFP program and a sufficient number of community residential program beds and nonresidential client slots. All were to be fully implemented by the end of fiscal year 1995, and an amendment authorized an additional 7,000 beds by the same time. The remaining 5,000 treatment beds were to be operational by the end of fiscal year 1996.

• In-Prison Therapeutic Community (ITC) Treatment System. In this program, prison-incarcerated offenders were to receive long-term (6 to 12 months), intensive chemical dependency treatment and habilitation before their return to the community. Clients who completed primary treatment in ITC facilities were to re-enter the community with the assistance of the same continuum of care received by the SAFP clients (noted above). In 1992, 600 beds were established, with another 500 added by the

end of the next fiscal year. The ITC system was to be fully operational—with 2,000 treatment beds—by the end of fiscal year 1995.

When the entire system was fully operational in 1996, there were to have been 28 ITC and SAFP facilities throughout Texas. The size of each facility ranged from 200 to 1,000 beds and was to serve a stable, maximum population of 14,000 (2,000 ITC and 12,000 SAFP clients). Clients were to progress through therapeutic community treatment cycles averaging 9 months.

On the basis of these numbers, Texas corrections officials projected that between 18,000 and 20,000 clients would be released from these in-custody treatment facilities and return to communities annually. This required approximately 4,000 new residential program beds and 17,000 new nonresidential program slots in the community.

Growth problems. Unfortunately, because of the unprecedented numbers of clients progressing through the system (a situation likely to continue for the foreseeable future), the Texas Initiative faces serious problems, which were created by its size and the push for rapid implementation (Fabelo, 1995). Among these problems are:

• An insufficiently experienced and trained staff.

• Too few quality post-release treatment programs to maintain continuity of care.

• A nonexistent selection/diagnostic process or one not adequate enough to ensure that offenders selected for the programs would be the ones likely to benefit from them.

• Management of the financial and accountability infrastructure that was inadequate for the expanded effort.

• Unrealistic expectations on the part of correctional officials for program success.

• An unrealistic anticipation of low attrition. (The State auditor reported an attrition rate of 58 percent and believes that correctional officials may have misled the legislature on this point.)

Evaluation findings. A 1-year followup study of 1,000 inmates referred to the in-prison treatment units showed favorable results (Fabelo, 1995). Only 7.2 percent of those who completed 3 or more months of treatment had been reincarcerated, in contrast to 18.5 percent of those who had received no treatment. There was a 42-percent dropout rate, although it is comparable to that of other modified prison-based TC programs.

That the intended 14,000 beds will probably not get much beyond 5,300 (*New York Times*, 1995) is not a tragedy, but an appropriate retrenchment, and at $188 million for the next 2 years, the program is not only the largest in the country but also the most expensive. However, some promising programming may be discontinued, notably a branch of Stay'n Out, the Lone Star Stay'n Out, opened in Amarillo in 1994.

New vision. The flagship program, the first TC in a private prison, is the 520-bed New Vision Chemical Dependency Treatment Facility, which opened in Kyle, near Austin, in 1992. The program, operated by Wackenhut (a private contractor), is likely to continue. An evaluation being conducted by Texas Christian University's Dwayne Simpson (Simpson and Knight, 1995) is revealing favorable results for the program.

Of the 343 inmates referred to New Vision during the second half of 1993, fully 80 percent successfully completed the program (of the others, 14 percent were expelled and the others left for medical or other reasons). The progress of graduates was compared with that of a matched sample from the general prison population who also met all treatment eligibility requirements but did not have enough time left to serve to be able to participate.

Data are available from half the scheduled 6-month followups. They revealed that 6 months after leaving prison, parolees who received TC treatment were less likely to be arrested than those who did not receive treatment (15 percent and 20 percent, re-

spectively) and less likely to have used cocaine or crack (7 percent and 26 percent, respectively).

The 61 percent who completed a 3-month residential care program after leaving prison did better on several outcomes—committing crime, being employed, and being arrested—than did parolees who did not complete the aftercare program. (See table 4.) Although the findings are not complete, they clearly support the importance of maintaining structured aftercare following prison TC treatment.

Table 4: **Texas New Vision Chemical Dependency Treatment Facility—Completion of Aftercare Produces Favorable Results**

	Completed 3 or More Months of Aftercare	Did Not Complete Aftercare
Committed Crimes for Income	1%	33%
Used Cocaine or Crack	35%	55%
Held Legal Employment	99%	77%
Arrested or Jailed	18%	55%

Wisconsin

Wisconsin's tradition of providing a systemwide approach to treating drug-abusing offenders dates back to 1975, when an alcohol treatment unit was established and was shown to be effective (Vigdal and Stadler, 1992; Vigdal, Stadler, Goodrick, and Sutton, 1980).

Program components. The State's current program includes the following components:

• Alternative to revocation, with 10 percent of the treatment spaces held for offenders who are being revoked and for whom no community treatment is available.

• Three special treatment programs, one for alcohol and two for other drugs.

• A 9- to 12-month residential TC for chronic heroin and cocaine addicts.

• Intensive supervision combined with drug testing, implemented by five teams of two officers each (with a 40-client caseload for each team).

• An intermediate sanction-day treatment program in which care is coordinated with correctional treatment facilities.

Diagnostic procedures—used to match the treatment with the offender—are also part of Wisconsin's program. The procedures cover alcohol dependence, involvement with other drugs, psychiatric impairment, and psychopathic tendencies.

California—Amity Prison TC

Intake data from California's State correctional facilities indicate that the number of drug offenders grew from just under 4,000 in 1984 to almost 20,000 in 1988; and in 1988 drug offense commitments constituted, for the first time, the largest category of felony commitments. Reacting to the growing need to ameliorate this situation, the California Department of Corrections (CDC) decided to participate in a research project that would examine the effectiveness of a modified TC for drug abusers. The result was the Amity Prison TC program, begun in 1989 and located at the R.J. Donovan Correctional Facility near San Diego.[9]

The program and its components. R.J. Donovan is a medium-security facility housing approximately 4,000 men in five self-contained living areas. All aspects of daily living—housing, sustenance, education, and work—are accommodated within these areas. One 200-man housing unit in one of these areas is designated for the Amity Prison TC program. The men who live in this housing unit participate in daily TC programming, which

is conducted largely by Amity, Inc. staff who work out of two trailers located near the housing unit.

Almost all inmates selected for the project are recruited through the reception center at the R.J. Donovan facility. Participants must meet several criteria for eligibility: They must have a history of drug abuse, demonstrate evidence of institutional participation (or absence of evidence of both in-prison assaults or weapon possession within the past 5 years and sex-related offenses in prison within the past 10 years), have no history of child molestation or mental illness, and be within 9 to 15 months of release on parole.

The program is modeled on New York's Stay'n Out; that is, it is a TC modified to fit a correctional setting. Program participants are housed in a residential unit separate from other inmates, although they eat in a common dining room and participate in activities with other inmates who live in the same yard.

Program phases. Treatment lasts about 12 months, during which participants move through three distinct phases of treatment. The first phase consists of orientation, diagnosis, and an assimilation process. Lasting 2 to 3 months, this phase involves clinical observation and assessment of residents' needs and problem areas. In this phase, prison TC procedures are learned, and there are encounter groups, seminars, and similar group activities. Residents are assigned prison industry jobs and are also given limited responsibility for maintenance of the TC.

During the second phase of treatment, which lasts 5 to 6 months, residents are given opportunities to take on positions of increased responsibility through involvement in the program and emotional "work." More seasoned residents are expected to share their insights by teaching the newer members of the community and by assisting in the day-to-day operation of the facility. In this phase, encounter groups and counseling sessions deepen in content and focus on self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. Seminars take on a more intellectual approach. Debate is encouraged as a means to enhance self-expression and to increase self-confidence.

During the third phase, community reentry, which lasts 1 to 3 months, inmates strengthen their skills in planning and decisionmaking and design their individual exit plans under the guidance of correctional, treatment, and parole staff.

The entire course of treatment is viewed as a developmental growth process in which the resident becomes an increasingly responsible member of the community. An important and unique program component is a core group of residents who are paid prison wages for holding key positions in the TC. These positions are earned by residents who have shown progress in the program and who have won the respect of the community through their hard emotional work.

Aftercare offered. Upon release from prison, graduates of the Amity Prison Project are offered the opportunity to continue in residential TC treatment for up to 1 year in a community facility also operated by Amity. The community TC can accommodate up to 40 residents. All residents share responsibility for the security, maintenance, and emotional health of the TC. The TC welcomes the wives, children, and parents of residents and offers special services to meet their needs as both clients and supporters in the recovery process.

The curriculum of the community TC builds upon what is offered in the prison and is individualized for each resident, depending on the level of progress achieved in the Prison TC treatment program. Prison TC residents who choose not to continue treatment in the community facility are encouraged to maintain strong ties to the house by joining weekly family groups, attending special functions sponsored by Amity, and by telephoning residents or Amity staff to update the house on their current situation and plans.

All graduates of the Amity Prison TC program and community TC's are encouraged to participate in treatment activities sponsored by other human service providers in the community (e.g., Alcoholics Anonymous and Narcotics Anonymous).

The prison TC program is staffed largely by veteran treatment counselors who have relocated from the Amity program in Tuc-

son, Arizona. Many program staff are role models, because they have histories of substance abuse and criminal offending and are graduates of community TC's. The Amity Program in Tucson and Continuance TC in Vista, California, provide ongoing staff training.

Amity evaluated. The prospective study of California's Amity Prison TC is based on an experimental design in which 720 male inmates are chosen randomly. Extensive followup is part of the study. A wide variety of background information and psychological data about program participants are collected at various points during the study: at admission, after 6 and 12 months while in the program, 12 months following release from prison, and 12 months following aftercare. The report of the evaluation (Wexler, 1995) was based on the first set of criminal record data obtained from the Centers for Disease Control and Prevention (CDC) and reflects findings after 6 months of program participation.

The data reveal information about the record of retention in the program and about recidivism (rearrest and reincarceration). Both retention and recidivism information is available for the first 189 participants who were paroled from the Donovan Prison; for 290 participants who were parolees, only information about reincarceration (after 1 year) was obtained.

Information on program retention and recidivism was obtained for four groups: clients who completed the prison TC program, clients who completed the prison TC plus the aftercare program, program dropouts, and a control group consisting of randomly selected inmates. There were no significant background differences among the group members: the proportion of whites, Hispanics, and blacks was similar in all four groups; the average age in all groups was 30 (and ranged from the early 20's to over 60); more than half had completed high school or received a GED certificate; and reading proficiency was at the seventh grade level. Sexual relations were for the most part limited to heterosexual partners.

For all four groups, various forms of stimulant drugs (other than alcohol and including cocaine, crack, and methamphetamine)

were the most widely used category of substances. They were used by 95 percent of the inmates. The preferred drugs were heroin and methamphetamine. More than half the group members (53 percent) reported ever using heroin, and this proportion was lower than the proportion who used any stimulant. Sixty percent of the inmates were IDU's (intravenous drug users), and nearly two-thirds of them shared needles with other drug users.

The study population consisted of hard-core felons; that is, they had extensive criminal histories, with an average of 321 offenses committed in their lifetime. More than 70 percent had committed a violent crime (assault, kidnapping, manslaughter, rape, or murder). Fifteen percent said they had committed murder and 3 percent reported having committed rape. Many have long criminal histories: half the study participants had been declared delinquent by a juvenile court, and the average inmate had spent more than half of his adult life in prison, with prison/jail terms averaging 19 years.

The psychological status scores were in the normal range and were significantly lower than in the psychiatric outpatient population. As expected, because the inmates were asked primarily about their criminal behavior, a very high proportion (52 percent) were diagnosed as having antisocial personalities. The unexpected finding that one out of five inmates evidenced intense phobic symptoms will be explored in later analyses.

Retention and recidivism. After 6 months, findings regarding retention in the program revealed that of the prison TC admissions, one-third were still enrolled and in good standing, half had completed the program, and the balance (17 percent) had been dropped because of serious infractions of prison policy or had left of their own volition. Approximately one in five graduates of the prison TC volunteered to participate in Amity's Vista community TC.

The findings regarding recidivism revealed that participants who went through both the program and the community-based TC had the lowest reincarceration rate of any group. Among participants who completed the program but did not go on to the community TC, the percent reincarcerated was higher. Moreover,

half the program drop-outs were reincarcerated, as were 63 percent of the control group subjects. (See table 5.) (These reincarceration results were statistically significant, as were the arrest results [not shown].)

Table 5: **California's Amity Prison TC: Percentage Reincarcerated One Year Following Parole**

Control Group (n=73)	Program Dropouts (n=48)	Completed Program (n=108)	Completed Program + Aftercare (n=61)
63.0%	50.0%	42.6%	26.2%

p<.01

It should be noted that inmates who completed treatment and program dropouts were at risk (i.e., had been released from prison) for a slightly shorter period—12 months—than the control group—15 months. These findings about recidivism outcomes are similar to those of the New York Stay'n Out prison program and compare favorably with national outcome evaluations of other community-based TC's.

Oregon's Cornerstone Program

The Cornerstone Program, located on the grounds of the Oregon State Hospital, is a 32-bed TC for correctional inmates that began in 1975 (Field, 1992). Somewhat like Stay'n Out, it is modeled on the TC concept but has a higher proportion of professional staff and trained correction officers than the New York program. The Stay'n Out staff consists largely of recovered addict ex-offenders.

Studies of recidivism and criminal activity. Two evaluation studies of Cornerstone examined several treatment outcomes, including recidivism (Field 1984, 1989). In the first study, a 3-year followup, the researcher looked at two outcome measures: not returning to prison and not being convicted of a crime. Program graduates were found to have had a significantly higher

success rate on both outcomes than did each of the other groups (dropouts and parolees). Three years after release, 71 percent of the graduates were not reincarcerated, whereas only 26 percent of the dropouts avoided reincarceration. Similarly, whereas slightly more than half the program graduates were not convicted of any crime (including minor offenses), this was true for less than 15 percent of the dropouts.

Program graduates also did significantly better than the other comparison group: the sample of Oregon parolees. Among parolees, 63 percent were not reincarcerated and only 36 percent were not convicted of any crime. The differences actually understate the effect of the treatment because the program graduates had significantly more severe criminal histories and substance abuse problems than the others.

The second study produced similar results, although it used a different research design. This time, three-fourths of the graduates were not reincarcerated compared with the other groups, of which 37 percent were not reincarcerated. The findings for the dropouts are even more dramatic. Only 8 percent of the clients who dropped out after less than two months in the program were not arrested during the 3-year followup, only 11 percent of them were not convicted, and only 15 percent were not reincarcerated. These findings are consistent with the those for the Stay'n Out program, which demonstrated that increased time in the program is associated with more positive treatment outcomes.

The arrest rate, the conviction rate, and the incarceration rate for the group of program graduates was lower than for each of the comparison groups. Furthermore, as the length of time in treatment increased, recidivism rates declined. Perhaps the most interesting findings pertain to the comparisons between the pretreatment and posttreatment intervals. Whereas the recidivism rates during both pretreatment intervals were about the same for each of the groups, recidivism rates during the posttreatment period were considerably lower among the program graduates. In addition, the decline in recidivism rates between the pretreatment and posttreatment periods was greatest for the program graduates (Field, 1989).

Cornerstone a model. Having shown evidence of positive outcomes in two evaluations, Cornerstone is now a model for three additional therapeutic communities, which also partially serve drug abuse offenders who are sex offenders, mentally ill, and mentally or socially retarded. Other programs in Oregon include:

• Two additional residential treatment programs.

• Correctional institutional group counseling through contracts with community treatment professionals.

• Several cooperative agreements for community treatment.

• A pilot program with subsidy funds for releasees who are high risks.

• A demonstration project to examine coordinated community services.

• The use of Alcoholics Anonymous and Narcotics Anonymous groups.

• Alcohol and drug education classes for alcoholics and addicts.

• Institutional information centers to assist inmate recovery.

In addition, all inmates are subject to random urine testing.

Followup study. The research on Cornerstone also indicated that the clients demonstrated enhanced self-esteem, reduced psychiatric symptoms, increased knowledge in critical treatment areas, reduced criminal activity, and reduced criminal recidivism. These manifestations were a function of the treatment program (Field, 1984).

The researcher followed up 220 people admitted to the program from 1983 to 1985, separating them into four groups—program graduates, nongraduates who completed at least 6 months of the program, nongraduates who completed 2 to 5 months, and nongraduates who left before 60 days. He found criminal activ-

ity continues to decrease for Cornerstone participants, but addicted offenders who receive little or no treatment show accelerated criminal activity. He also found that as the amount of time in treatment increases, criminal activity decreases. Finally, the followup study indicated that the number of arrests, convictions, and incarceration are about equally accurate as measures of success/failure.

Delaware's Key-Crest Program

The Key-Crest program is a three-stage treatment model program operating within the correctional system of the State of Delaware. Only the first two stages are operating. The program is built around two TC's: the "Key," a prison-based TC for men and the "Crest," a residential work release center for both men and women.

Three-stage program. The concept of the Key, the primary stage of treatment, is modeled on the Stay'n Out program and is a 12-month intensive residential TC based in the institution. In the institution there is time for comprehensive treatment, because time and isolation are resources used for working on problems, and the competing demands of the street, work, friends, and family are absent.

The Key-Crest program is distinctive because of its secondary stage of treatment—a "transitional TC," which is a TC work release program. In this stage, inmates who are nearing their release date are allowed to hold paying jobs in the outside community while spending their nonworking time in a "family setting" similar to a traditional TC. The third stage (aftercare) is for released inmates, now parolees, who have completed the first two stages and are living in the outside community under parole or other supervision. Intervention at this stage involves outpatient group and individual counseling and the opportunity to return to the work release TC for refresher/reinforcement sessions, to attend weekly groups, and to spend one day a month at the work release TC.

Stage 1 and 2 studied. A study of drug-involved offenders who experienced the first two stages (prison-based TC followed by

work release TC) revealed surprisingly positive results. The characteristics of the study group were as follows: 81 percent were men, 72 percent were African American, 82 percent previously had drug treatment, the average (mean) age was 29.6 years, the age at first arrest was 17, and the number of previous incarcerations was two.

The design of the evaluation study contrasted participants in the Key alone, participants in Crest alone, and participants in the combined Key-Crest program with inmates who received no treatment other than HIV prevention education. After controlling for other factors (such as number of days in treatment, time since discharge, and number of times previously incarcerated), the researcher found highly positive results as measured by percentage drug-free and arrest-free after 6 months.

Essentially, program participants did much better at staying drug-free than did the comparison group (which received HIV-education only). The group that fared best after 6 months were those in the Key and the Crest combined. Those in the Crest work release did better than those in the Key alone, and all three of these treatment groups did better than the comparison group. When the researchers examined the proportions who remained arrest-free, they found similar results (Lockwood, Inciardi, and Surratt, 1995; Martin, Butzin, and Inciardi 1995; Inciardi, 1995). (See table 6.)

After 18 months the percentages who remained drug-free declined somewhat (Inciardi, 1995). (See table 6.) The results suggest the pattern of improvement with increasing exposure to the TC continuum is maintained since the 6-month point, even after controlling for a number of potential covariates. Participants in Crest and Key-Crest are significantly more likely to be drug-free than the comparison group, although the Key group was not significantly different from the comparison group (Inciardi, 1995).

Time-in-program. The pattern of improvement with increasing exposure may also be seen in the data on arrests after 18 months. (See table 6.) They confirm the relative improvement generated by the work release TC, rather than an in-prison TC only, but continue to indicate the strongest and most consistent pattern of

success comes from the group that receives the full continuum of TC treatment. This was evident in the results of the Amity Prison TC and Stay'n Out studies.

Table 6: **Key-Crest Participants Tended to Remain Drug-Free and Arrest-Free Longer**

After 6 Months	Key-Crest	Crest Only	Key Only	HIV-Education
Drug-Free	94%	84%	54%	38%
Arrest-Free	92%	85%	82%	62%
After 18 Months	**Key-Crest**	**Crest Only**	**Key Only**	**HIV-Education**
Drug-Free	75%	46%	34%	17%
Arrest-Free	72%	60%	46%	36%

Controlling for gender, race, age, prison history, treatment history, and previous drug use.

Exposure to TC at Key-Crest produced other benefits that can be seen in some additional 18-month outcome data. These include significant reductions in the use of injection drugs, in the amount of income from crime in the previous year, and in fewer returns to prison for new sentences among those who attended Crest compared to those who did not. The robust findings through two stages of research are that length of time in treatment and the degree of involvement in treatment are important for success and that even controlling for these influences, participation in the prison TC in combination with the work release TC treatment continuum significantly improves outcome (Inciardi, 1995).

The TASC Program

There are many drug-using offenders who could benefit from being diverted from incarceration and who would not, under appropriate levels of supervision, present a serious risk to the community. A successful vehicle for accomplishing this is the Treatment Alternatives to Street Crime (TASC) program, which, working together with parole, can successfully and systematically intervene.

TASC Components

TASC provides case management for drug-abusing defendants and offenders, serving as a bridge between criminal justice agencies (courts and probation) and treatment providers. Currently there are more than 180 TASC projects in 27 States and 2 territories. They provide screening, assessment, treatment planning, monitoring, urinalysis, and court liaison functions (Personal Communication, Kenneth W. Robertson, Executive Director, National Consortium of TASC Programs, 1993).

The concept of TASC emerged from research showing treatment is more effective in settings in which legal sanctions and close supervision provide incentives for clients to conform with treatment program protocols and objectives. Longer duration of treatment is consistently associated with better treatment outcome, and clients under legal coercion generally stay in treatment longer than those who are not.

Case management, through TASC, incorporates support, staff training, data collection, client identification based on eligibility criteria, assessment and referral, urinalysis, and monitoring (Weinman, 1992). TASC clients remain in treatment 6 to 7 weeks longer than other criminal justice clients, whether referred to residential or outpatient programs.

TASC and Prison Crowding

If TASC or TASC-like programs were available in more cities, many more people, particularly young people, could be di-

verted to treatment. Unfortunately, with recent upward trends in drug-related crimes, the demand for treatment programs is far greater than the treatment system can provide. Thus, not only must there be more programs for offenders who are incarcerated but a great deal more for those on probation or in other community supervision statuses. Several studies indicate that TASC has been successful in reducing prison crowding and facilitating treatment through the TASC and parole partnership. Only now, however, is a formal research evaluation taking place.[10]

CDATE—a Retrospective Overview of Evaluative Research

The therapeutic community is not the only modality that has shown positive outcomes among drug-abusing offenders. The National Development and Research Institutes, Inc. in New York is assembling the results of 25 years of correctional evaluation research in a project called CDATE: Correctional Drug Abuse Treatment Effectiveness. CDATE is a comprehensive, detailed review of the evaluation research that has been conducted on rehabilitation programs for offenders in general. Special attention is being given to drug treatment offered to offenders in all levels of criminal justice custody. The project, which began in 1994 and will be completed in 1996, was funded by the National Institute on Drug Abuse.

Research Goals

The research consists of assembling, annotating, and analyzing all studies conducted since 1968; that is, since the studies reported in 1975 in *The Effectiveness of Correctional Treatment: A Survey of Treatment Evaluation Studies*. Goals of the current study include the following:

• Seek *all* credible evaluation studies of treatment of offenders, drug abusing and non-drug abusing alike.

• Examine and assemble these studies in a way that can best inform policy and practice.

• Assess the effectiveness of the most advanced correctional treatment.

More specific aims include the following:

• Develop a comprehensive information data base of correctional treatment evaluation studies from all countries completed between 1968 and 1994.

• Categorize and systematically annotate all these studies, noting participation by and outcomes for offenders with drug abuse histories.

• Critically evaluate the study methodologies.

• Assess the effect of the various treatments on several outcome measures, particularly drug abuse and recidivism.

• Describe the policy implications of the results for correctional treatment programming, training, staffing, program implementation, programmatic evaluation, and future research.

• Describe each modality of treatment for offenders in detail in terms of size, variety, clientele, goals, staff, setting, relative isolation, use of incentives, duration, frequency, intensity, priority, completeness of implementation, relationship to drug abuse, continuity of treatment, outcome, and many other factors.

• Describe and analyze each outcome criterion (for example, relapse to drug use, recidivism) in terms of variety, relative precision, and utility for evaluations of correctional treatment for non-drug abusing offenders as well as drug abusers.

• Perform a meta-analysis to compare the effect of each treatment on each of the outcomes; compare the size of the effects for different population subsets (for example, gender, age, and race groupings), and assess the degree to which a variety of independent variables

(e.g., treatment methods, program characteristics, client characteristics, research methodologies) affect evaluation findings.

• Widely disseminate findings on "what works" to practitioners, policymakers, and legislators in correctional treatment for non-drug abusers as well as drug abusers.

• Deposit the entire collection of articles, documents, and other materials and annotations in a publicly accessible library and, depending on availability of funding, make the entire data set available on CD-ROM.

Also being compiled, translated, and added to the analysis are the contributions of the correctional evaluation research work of scientists in other countries over the past 25 years—chiefly from Canada, Great Britain, Australia, Netherlands, Germany, Norway, Denmark, and Sweden. These contributions will be incorporated into this compendium of the literature of correctional rehabilitation and into the meta-analysis.

Conclusion—A Sound Investment

Addiction treatment is a critical component of the Nation's war on drugs, and the incarceration of people found guilty of various crimes who are also chronic substance abusers presents a propitious opportunity for treatment. It is propitious because these people would be unlikely to seek treatment on their own. Without treatment they are extremely likely to continue their drug use and criminality after release, and we now appear to have cost-effective technologies to effectively treat them while they are in custody and thus alter their life styles. Moreover, it appears that the technologies may be sufficiently strong to treat violent offenders as well.

Evidence Based on Sound Research

The studies of New York's Stay'n Out program, Oregon's Cornerstone program, California's Amity Prison TC program, and Delaware's Key-Crest program, described here, are the first large-scale research evaluations to provide solid evidence that prison-based TC treatment can produce significant reductions in recidivism rates among chronic drug-abusing felons and *to show consistency of such results over time*.

This is not to say that prison-based TC's have not been successful before but that formal research evaluations have not been undertaken before these. In fact TC's have been used since the early 1950's in many Federal and State prisons, and most lasted about 7 to 9 years, usually until budget priorities changed. It is worth noting that the success of this type of holistic treatment is probably due to the fact that it deals with many of the inmates' social and psychological problems, which prevent them from returning to acceptable social functioning. It deals with the myriad problems associated with the lifestyle of addiction as well as the drug use—and is therefore more likely to be successful in the long run than treatment programs that focus mainly on drug abuse.

The Benefits Are Worth the Costs

The cost-effectiveness of the treatment supports its implementation even more. Programs like Stay'n Out cost about $3,000 to $4,000 more than the standard correctional costs per inmate per year. (Programs like Cornerstone, with more professional staff and one-fourth the caseload per staff member, cost a little over twice as much for the same time period.) The savings produced in crime-related and drug use-associated costs, however, pay for the cost of the treatment in about 2 to 3 years.

It is an inescapable conclusion that treatment lowers crime and health costs as well as the associated social and criminal justice costs. Moreover, the higher the investment in rehabilitating the most severe offender-addicts, the greater the probable effect. The most serious chronic heroin and cocaine users (about 3 percent to 10 percent of all offenders, depending on jurisdiction) are each responsible for a high volume of predatory crime (Gropper, 1985 based on the work of Johnson et al., 1985; Ball et al., 1983; and Inciardi, 1979). Substantial reductions in the high-volume criminality of this group has an immediate effect on the quality of our lives. Without intervention, this group will return to crime and drug use 9 times out of 10 after release, and most will be back in custody within 3 years. With appropriate intervention provided for a sufficient duration, more than three out of four will succeed; that is, reenter the community and subsequently lead a socially acceptable life.

This highly predatory group of criminals is amenable to long-term (9- to 12-month) TC treatment while incarcerated (or in a combined program begun in the institution and continued in the community) and is unlikely to benefit significantly from treatment lasting less than 6 months.

Cause for Optimism

It is important to note the consistency of the findings irrespective of locale and populations—unusual in correctional evaluation research. Moreover, the findings are relevant for more than drug offenders, because a great many of the successful graduates

of these programs had histories of violent crime. This has important implications for the use of this modality for offenders because very few programs using other methods have been as successful.

I am genuinely optimistic about our ability to effectively treat people normally deemed by conventional wisdom to be "very high risk" (that is, chronic heroin and cocaine users with extensive predatory criminal histories). Careful evaluations of interventions in several States with diverse populations show remarkably consistent levels of success. There appears to be mounting evidence that high-rate addict-felons who each commit 40 to 60 robberies a year, 70 to 100 burglaries a year, and many violent offenses, as well as conduct more than 4,000 drug transactions a year, can be effectively and cost-efficiently helped. We have reliable evidence from studies of diverse areas that has demonstrated a substantial reduction in recidivism after treatment—a reduction of sufficient size to yield a tangible improvement in our quality of life.

Notes

1. The Drug Use Forecasting program (DUF), administered by the National Institute of Justice, tests booked arrestees for a variety of drugs in selected major metropolitan areas.

2. Reported in various articles in the *New York Times*, January 1992, April 1993, May 1994, and March 1995, as well as in the *Philadelphia Inquirer*, *Newark Star Ledger*, and *Baltimore Sun*.

3. The Drug Abuse Warning Network, administered by the U.S. Department of Health and Human Services.

4. Along with my colleague Harry Wexler, I was involved in helping the States with these initiatives. The States that had Project REFORM programs were Alabama, Connecticut, Delaware, Florida, Hawaii, New Jersey, Oregon, Washington, California, New York, and New Mexico.

5. The States were Colorado, Georgia, Michigan, North Carolina, North Dakota, Pennsylvania, and Virginia. Texas and Ohio also participated in RECOVERY activities. It was Texas' participation with RECOVERY staff that facilitated and infused the Texas Initiative.

6. The information is from a survey conducted by the American Jail Association to examine the scope of drug abuse treatment services in jails throughout the country. A little over half (57 percent) of the 1,737 jails responded (Peters and May, 1992).

7. The evaluation was conducted by National Development and Research Institutes, Inc., with funding from the National Institute on Drug Abuse.

8. The difference was statistically significant at the $p<.05$ level; that is, the probability is less than 1 in 20 it could have happened by chance.

9. The program is operated by Amity, Inc., with funding by the California Department of Corrections. The program evaluation

is under the direction of Harry Wexler and is funded by the National Institute on Drug Abuse as part of the Center on Therapeutic Community Research, directed by George De Leon for National Development and Research Institutes, Inc.

10. The study is directed by James Inciardi and Duane McBride, among others.

References

Andrews, D.A. et al. (1990). "Does correctional treatment work? A clinically-relevant and psychologically-informed meta-analysis." *Criminology* 28(3):369–404.

Bailey, W.C. (1966). "Correctional outcome: an evaluation of 100 reports." *J. Criminal Law, Criminology and Police Sciences* 57(2):153–160.

Ball, J.C., Rosen, L., Flueck, S.A., and Nurco, D.N. (1981). "The criminality of heroin addicts when addicted and when off opiates." In: J.A. Inciardi (ed.), *The Drugs-Crime Connection*. Beverly Hills, CA: Sage: 39–65.

Ball, J.C., Shaffer, J.W. and Nurco, D.N. (1983). "Day-to-day criminality of heroin addicts in Baltimore: A study in the continuity of offense rates." *Drug and Alcohol Dependence* 12: 119–142.

Beck, Allen J., and Gilliard, Darrell K. *Prisoners in 1994* (August 1995). Bureau of Justice Statistics Bulletin. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Bell, W.C., Mitchell, J.G., Williams, B.T., Benvino, J., and Darabi, A. (1992). "Florida Department of Corrections substance abuse programs." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 110–125). Washington, DC: U.S. GPO.

Brenna, D. (1992). "Substance abuse services in juvenile justice: the Washington experience." In C.G. Leukefeld and F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 99–109). Washington, DC: U.S. GPO.

Brown, B.S. (1992). "Program models." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 31–37). Washington, DC: U.S. GPO.

Bureau of Justice Statistics. (1994). "State and Federal prison population tops one million." Press release. Washington, DC: U.S. Department of Justice, October 17.

Bureau of Justice Statistics. (1992). *Drugs, Crime, and the Justice System 1992*. Washington, DC: U.S. Department of Justice.

Chaiken, M.R. (1986). "Crime rates and substance abuse among types of offenders." In: B.D. Johnson and E.D. Wish (eds.), *Crime Rates Among Drug-Abusing Offenders: Final Report to the National Institute of Justice.* NY: Narcotic and Drug Research, Inc.

Chaiken, M.R. (1989). *In-Prison Programs for Drug-Involved Offenders.* Research in Brief. Washington, DC: National Institute of Justice.

Cullen, F., and Gendreau, P. (1989). "The effectiveness of correctional rehabilitation." In: Goodstein, L., and MacKenzie, D.L. (eds.), *The American Prison: Issues in Research Policy*. NY: Plenum.

"Drug use forecasting update." *NIJ Reports,* No. 21 (July/August 1989): 819.

Fabelo, T. (1995). "Why it was prudent not to expand the correctional substance abuse treatment initiative." *Bulletin from the Executive Director,* No. 16. Criminal Justice Policy Council, July.

Fagan, J., Belenko, S., Johnson, B., Chin, K.L., and Dunlap, E. (1990). *Changing Patterns of Drug Abuse and Criminality Among Crack Cocaine Users.* Summary Final Report. NY: New York Criminal Justice Agency, January.

Field, G. (1984). "The cornerstone program: A client outcome study." *Federal Probation,* 48, 50–55.

Field, G. (1989). "A study of the effects of intensive treatment on reducing the criminal recidivism of addicted offenders." *Federal Probation* 53(10):51–56.

Field, G. (1992). “Oregon prison drug treatment programs.” In C.G. Leukefeld and F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* pp. 142–155. Washington, DC: U.S. GPO.

Fletcher, B., and Tims, F.M. (1992). “Methodological issues in researching drug abuse treatment in prisons and jails.” In C.G. Leukefeld and F. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 246–260). Washington, DC: U.S. GPO.

Frohling, R. (1989). *Promising Approaches to Drug Treatment in Correctional Settings.* Criminal Justice Paper No. 7. National Conference of State Legislatures, Washington, DC.

Gendreau, P., and Ross, R.R. (1979). “Effective correctional treatment: bibliography for cynics.” *Crime and Delinquency* 25(4):463–489.

Gerstein, D.R, and Harwood, H. (eds.) (1992). *Treating Drug Problems, Volume 2*. National Academy of Sciences, Institute of Medicine. Washington, DC: National Academy Press.

Greenwood, P.W., and Zimring, F. E. (1985). *One More Chance: The Pursuit of Promising Intervention Strategies for Chronic Juvenile Offenders*. Santa Monica: RAND.

Gropper, B.A. (1985). *Probing the Links Between Drugs and Crime.* Washington, DC: National Institute of Justice.

Hawk, K.M. (1995). Testimony before the House Judiciary Committee, Subcommittee on Crime, June 8, 1995.

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

Inciardi, J.A. (1979). “Heroin and street crime.” *Crime and Delinquency*. 25:333–346.

Inciardi, J.A., Horowitz, R., and Pottieger, A. E. (1993). *Street Kids, Street Drugs, Street Crime: An Examination of Drug Use*

and Serious Delinquency in Miami. Belmont, CA: Wadsworth Pub. Co.

Inciardi, J.A. (1995). "The therapeutic community: An effective model for corrections-based drug abuse treatment." In K.C. Haas and G.P. Alpert (eds.), *The Dilemmas of Punishment* (pp. 406–417). Prospect Heights, IL: Waveland Press.

Izzo, R.L., and Ross, R.R. (1990). "Meta-analysis of rehabilitation programs for juvenile delinquents." *Criminal Justice and Behavior* 17:134–142.

Johnson, B.D., Goldstein, P.J., Preble, E., Schmeidler, J., Lipton, D.S., Spunt, B. and Miller,T. (1985). *Taking Care of Business: The Economics of Crime by Heroin Abusers*. Lexington, MA: Lexington Books.

Johnson, B.D., Lipton, D.S. and Wish, E.D. (1986). *Facts About the Criminality of Heroin and Cocaine Abusers and Some New Alternatives to Incarceration.* NY: Narcotic and Drug Research, Inc.

Kirby, B.C. (1954). "Measuring effects of treatment of criminals and delinquents." *Sociology and Social Research* 38:368–374.

Lab, S.P., and Whitehead, J.T. (1988). "An analysis of juvenile correctional treatment." *Crime and Delinquency* 34:60–83.

Leukefeld, C.G., and Tims, F.M. (eds). (1988). *Compulsory Treatment for Drug Abuse: Research and Clinical Practice* (NIDA Research Monograph No. 86). Washington, DC: U.S. GPO.

Lipsey, M.W. (1989). *The Efficacy of Intervention for Juvenile Delinquency: Results From 400 Studies.* Paper presented at the 41st annual meeting of the American Society of Criminology, Reno, NV.

Lipsey, M.W. (1991). "Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects." *Meta-Analysis for Explanation: A Casebook.* NY: Russell Sage.

Lipton, D.S., Martinson, R., and Wilks, J. (1975). *The Effectiveness of Correctional Treatment.* New York: Praeger Publishers.

Lipton, D.S., Morales Edmundo, and Douglas S. Goldsmith. (1989). *Pathways Into Treatment: A Study of the Drug Treatment Entry Process.* Final Report of NIDA Project 1 R01 DA–03929–01. NY: Narcotic and Drug Research, Inc.

Lipton, D.S., Falkin, G.P., and Wexler, H.K. (1992). "Correctional drug abuse treatment in the United States: an overview." In *Drug Abuse Treatment in Prisons and Jails*, ed. C.G. Leukefeld and F.M. Tims, 8–30. NIDA Monograph No. 118. HHS. Rockville, MD: USGPO.

Lipton, D.S. (1994). "The correctional opportunity: pathways to drug treatment for offenders." *Journal of Drug Issues*, 24 (1&2) 1994: 331–348.

Lockwood, D., Inciardi, J.A. and Surratt, H. (In press). "CREST outreach center: A model for blending treatment and corrections." In J. Inciardi, B. Fletcher, P. Delany, and A. Horton (eds.), *The Effectiveness of Innovative Approaches in the Treatment of Drug Abuse.* Westport, CT: Greenwood Press.

Logan, C.H. (1972). "Evaluation research in crime and delinquency: A reappraisal." *Journal of Law, Criminology and Police Science*, 63 (3): 378–387.

Magura, S., Rosenbaum, A., and Joseph, H. (1992). "Evaluation of in-jail methadone maintenance: preliminary results." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 192–210). Washington, DC: U.S. GPO.

Martin, S.S., Butzin, C.A., and Inciardi, J.A. (1995). "Assessment of a multi-stage therapeutic community for drug involved offenders." *Journal of Psychoactive Drugs*, 27(1):109–116.

Martinson, R. (1974). "What works? Questions and answers about prison reform." *The Public Interest*, 35:22–54.

Martinson, R. (1979). "New findings, new views: a note of caution regarding sentencing reform." *Hofstra Law Review* 7:243–258.

Murray, D.W. (1992). "Drug abuse treatment programs in the Federal Bureau of Prisons: initiatives for the 90's." In C.G. Leukefeld and F. M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 62–83). Washington, DC: U.S. GPO.

National Institute on Drug Abuse. (1981). *Drug Abuse Treatment in Prisons.* Treatment Research Report Series. Washington, DC: National Institute on Drug Abuse, U.S. GPO.

National Institute of Justice. (1994). Research in Brief. *Drug Use Forecasting 1993. Annual Report on Adult Arrestees: Drugs and Crime in America's Cities.* Washington, DC: U.S. Department of Justice.

New York Times, January 14, 1992, pp. A1, B2.

New York Times, July 4, 1995, p. 37.

Palmer, T. (1975). "Martinson revisited." *Journal of Research in Crime and Delinquency* 12:133–152.

Pellissier, B., and McCarthy, D. (1992). "Evaluation of the Federal Bureau of Prison's drug treatment programs." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 261–278). Washington, DC: U.S. GPO.

Peters, R., and May, B. (1992). "Drug treatment services in jails." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 38–50). Washington, DC: U.S. GPO.

Peyton, E. A. (1994). *A Coordinated Approach to Managing the Drug Involved Offender*. The Second Report of the Treatment Access Committee, Delaware Sentencing Accountability Commission, March 11, 1994.

Platt, J.J., Perry, G.M., and Metzger, D.S. (1980). "The evolution of a heroin addiction treatment program within a correctional environment." In Ross, R.R., and Gendreau, P., (eds.), *Effective Correctional Treatment*. Toronto: Butterworths.

Prendergast, M.L., Hser, Y.I., Chen, J., and Hsieh, J. (1992). *Drug Treatment Need Among Offender Populations.* Paper presented at the American Society of Criminology, New Orleans, LA, November 4–7.

Reuter, P. (1992). *Hawks Ascendant: The Punitive Trend of American Drug Policy*. Santa Monica: RAND.

Rosenbaum, D. P. (1988). "Community Crime prevention: a review and synthesis of the literature." *Justice Quarterly* 5(3):323–395.

Sechrest, L., White, S.O., and Brown, E.D. (eds.) (1979). *The Rehabilitation of Criminal Offenders: Problems and Prospects.* Washington, DC: National Academy of Sciences.

Simpson, D. and Knight, K. (1995). *Preliminary Results From the Institute for Behavioral Research's Prison-Based Treatment Assessment Project.* Paper presented at the Fifth National Conference on Drugs and Crime, Orlando, FL. Reported in IBR's Quarterly Newsletter, *Research Roundup*, 5(2), Summer 1995.

U.S. General Accounting Office. (1991). *Drug Treatment: State Prisons Face Challenges in Providing Services*. GAO/HRD–91–128. Washington, DC: U.S. GAO, September.

Van Voorhis, P. (1987). "Correctional effectiveness: The high cost of ignoring success." *Federal Probation* 51 (March):56–62.

Vigdal, G.L. and Stadler, D.W. (1989). "Controlling inmate drug use: cut consumption by reducing demand." *Corrections Today* 51 (3): 96–97.

Vigdal, G.L., and Stadler, D.W. (1992). "Comprehensive system development in corrections for drug abusing offenders: The Wisconsin Department of Corrections." In C.G. Leukefeld and

F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 126–141). Washington, DC: U.S. GPO.

Vigdal, G.L., Stadler, D.W., Goodrick, D.D., and Sutton, D.J. (1980). "Skills training in a program for problem-drinking offenders: a one year follow up evaluation." *Journal of Offender Counseling and Rehabilitation*, 5: 61–73.

Walters, G. (1992). "Drug-seeking behavior: disease or lifestyle." *Professional Psychology: Research and Practice* 23(2): 139–145.

Weinman, B. (1992). "A coordinated approach for drug abusing offenders: TASC and parole." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 232–245). Washington, DC: U.S. GPO.

Wexler, H.K., Lipton, D.S. and Johnson, B.D. (1988). *A Criminal Justice System Strategy for Treating Cocaine-Heroin Abusing Offenders in Custody*. Issues and Practices Paper in Criminal Justice. U.S. GPO. No. 1988–202–045:8–0082 Washington, DC: National Institute of Justice, March.

Wexler, H.K. Falkin, G.P., and Lipton, D.S. (1990). "Outcome evaluation of a prison therapeutic community for substance abuse treatment." *Criminal Justice and Behavior*. 17(1): 71–92.

Wexler, H.K., Lipton, D., Falkin, G.P., and Rosenbaum, A.B. (1992). "Outcome evaluation of a prison therapeutic community for substance abuse treatment." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 156–175). Washington, DC: U.S. GPO.

Wexler, H.K. (1995). *Amity/Prison TC: One-Year Outcome Results.* Unpublished report to NDRI.

Whitehead, J.T. and Lab, S.P. (1989). "A meta-analysis of juvenile correctional treatment." *Journal of Research in Crime and Delinquency* 26:276–295.

Wilson, John Q. (1975) *Thinking About Crime*. NY: Vintage Books.

Winett, D.L., Mullen, R., Lowe, L.L., and Missakian, E.A. (1992). "Amity/Prison TC: A State of California demonstration drug abuse treatment program for inmates and parolees." In C.G. Leukefeld and F.M. Tims (eds.), *Drug Abuse Treatment in Prisons and Jails* (pp. 84–98). Washington, DC: U.S. GPO.

Wish, E.D., and O'Neil, J.A. (1989, September). *Drug Use Forecasting (DUF)*. Research Update, January to March, 1989. Washington, DC: U.S. Department of Justice: National Institute of Justice.

For more information on the National Institute of Justice, please contact:

National Criminal Justice Reference Service

Box 6000
Rockville, MD 20849–6000
800–851–3420
E-mail: askncjrs@ncjrs.aspensys.com

You can view or obtain an electronic version of this document from the NCJRS Bulletin Board System (BBS) or the NCJRS Justice Information Center World Wide Web site.
To access the BBS, direct dial through your computer modem: (301) 738–8895 (modems should be set at 9600 baud and 8–N–1), or
Telnet to ncjrsbbs.aspensys.com or
Gopher to ncjrs.aspensys.com 71

To access the World Wide Web site, go to http://ncjrs.aspensys.com:81/catalog.html

If you have any questions, call or e-mail NCJRS.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, Bureau of Justice Statistics, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

Washington, D.C. 20531

Official Business
Penalty for Private Use $300

BULK RATE
POSTAGE & FEES PAID
DOJ/NIJ
Permit No. G–91