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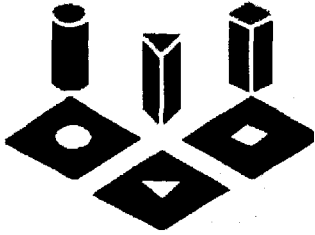
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**Evaluating the Implementation & Impact of a Seamless System
of Care for Substance Abusing Offenders – The HIDTA Model**

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Draft

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EXECUTIVE SUMMARY

Introduction

By the end of the year 2000, more than 6.5 million adults were under the supervision of the correctional system, and more than half of these offenders are estimated to have significant substance abuse problems.

Traditional, boundary-laden treatment and control strategies have been unable to change offender drug use and criminal behavior. Among the state probation populations, the proportion of offenders who successfully complete their supervision has dropped from seventy (70) percent to sixty (60) percent in the past decade, due in large part to offenders' failure to abide by the conditions of their release related to abstinence from drug/alcohol use and/or participation in treatment. In 1999 alone, fourteen (14) percent of the probation population (244,700) and forty two (42) percent of the parole population (173,800) were returned/sent to prison for a rule violation and/or a new offense. Invariably, this is the result of the offender's continued involvement in drug use and/or drug-related criminal behavior. Without significant increases in resource levels, treatment availability and quality will continue to be major barriers to offender change. The question that remains is how to utilize the leverage of the criminal justice system in a manner that supports-rather than subverts-treatment goals.

The HIDTA Model: A Seamless System of Drug Treatment and Offender Control

In response, the Office of National Drug Control Policy (ONDCP) sponsored a demonstration project that commenced in 1994 to pilot new strategies to improve treatment services to

offenders, specifically the formulation of a new model of incorporating treatment within the criminal justice system – the Seamless System of Care. The HIDTA Model was designed to target hard-core, substance abusing offenders who are both difficult clients for treatment providers and difficult offenders for community supervision agents. Part of this demonstration project was the restructuring of the treatment and supervision delivery systems for criminal justice offenders within the High Intensity Drug Trafficking Areas (HIDTA) program in the Washington, DC - Baltimore corridor. Each of the 12 participating jurisdictions (VA: Alexandria City, Arlington County, Fairfax/Falls Church, Loudon County, Prince William County; MD: Baltimore City, Baltimore County, Charles County, Howard County, Montgomery County, Prince William County, and the District of Columbia) developed a seamless system tailored to their own socio-legal environment which included system reforms consistent with the core components of the HIDTA model.

The HIDTA model is based on the concept of the boundaryless system that “transcends the traditional organizational boundaries to focus attention on improved outcomes”(Taxman & Bouffard:2000:41). Specifically, a main objective of the ONDCP demonstration project was to redefine the relationship between the criminal justice and treatment systems from one based on the brokerage of services (case management) to one defined by rationing and triage (*systemic* case management). The four key components of the HIDTA seamless system include: (1) continuum of care, (2) supervision, (3) urinalysis testing, and (4) compliance measures and graduated sanctions.

Evaluation Data and Methods

This evaluation report provides a detailed examination of the development, implementation, and initial impact of the High Intensity Drug Trafficking Areas (HIDTA) Model, based on a multi-site (12 jurisdictions) analysis of the program. Using a simple pre-post, non-experimental design, data were collected at each of these twelve sites on the total population of offenders admitted to the HIDTA program in 1997 (N=1,216). By using a non-experimental design to conduct our initial review, we could provide preliminary outcome data to jurisdictions while focusing our evaluation resources on the critical question of level of implementation. Data were collected on the following: (1) demographic and criminal history, (2) treatment placement and movement through treatment, (3) criminal justice supervision and services, (4) drug testing results, and (5) the use of graduated sanctions by either the treatment agency or the criminal justice agency. The integration of records from treatment providers and criminal justice agency providers was critical to assessing the impact of the HIDTA Model on the offenders included in this study.

The HIDTA offender was most likely to be an African-American male in his mid-thirties, who was not employed at the time of his arrest. The typical offender had an average of ten prior arrests and five prior convictions, with at least one prior period of incarceration. Further, examination of the criminal careers of these offenders underscores the fact that they have been criminally active for several years - the typical offender averaged a little over one arrest per year for the past nine years. These offenders are currently in the criminal justice system because of their drug problem. Nearly 45% of these offenders had a drug charge with half of the charges involving distribution or possession with intent to distribute. It appears that the typical HIDTA

offender is a low-level drug dealer who deals to support his/her addiction to drugs. The drug of choice for these offenders is either crack/cocaine (28.2%) or heroin (19.8%), consumed by smoking (39.2%), injection (12.7%), or some other oral means (17.4%). Although the treatment histories of HIDTA offenders are often unknown at the time of HIDTA intake, it appears that the majority of these offenders are addicts who have been in treatment before but who remain – based on their own self-report response – addicted to drugs. In fact, one of every three HIDTA offenders reported daily drug use at the time of their arrest. Clearly, there is significant overlap between the addiction careers and the criminal careers of these offenders.

Level of Program Implementation

The purpose of our implementation (or process) evaluation is two-fold: first, to determine the extent to which the HIDTA model was implemented as designed; and second, to document changes in each jurisdiction's response to offenders during the pre-post comparison period. Overall, the HIDTA model was not fully implemented in 8 of the 12 jurisdictions. However, major changes in practices were identified across all 12 jurisdictions, especially in the areas of continuum of care and drug testing. Unfortunately, data collection problems prevented the assessment of supervision levels and systemic case management practices.

Continuum of Care Implementation. There were site-specific variations in the development of a comprehensive continuum of care system, which can be directly linked to resource constraints faced by program developers in these jurisdictions. Our review identified five jurisdictions with the residential/outpatient model, three jurisdictions with the intensive care facility/outpatient model, six jurisdictions with the intensive outpatient model, and six jurisdictions with the jail-

based treatment/outpatient model. Only one jurisdiction (Montgomery County) developed a continuum of care system that incorporates all four modalities. Overall, the average successful completion rate for HIDTA treatment participants was 64 percent, which was much higher than anticipated given the target population selected. The average time in treatment for HIDTA participants was 208 days (range 172-265 days).

Drug Testing Implementation. Drug testing schedules varied considerably across the twelve jurisdictions we examined: one site used random drug testing; three sites tested offenders three times per month; one site tested offenders weekly; and seven sites conducted drug tests twice per week. Thirty-five percent of HIDTA participants tested positive for drugs between the time of arrest and the time of intake to treatment. During this pre-treatment period, the drug of choice was crack/cocaine (11%), marijuana (6%), and heroin (5%). Overall, 18 percent of HIDTA participants tested positive for drugs during the treatment period. When compared to the pretest results, this represents a 49 percent decline in the test positive rate (from 35 percent to 18 percent). Offenders testing positive for drugs during treatment were more likely to test positive for marijuana than any other drug, which suggests a reduction in seriousness of drug use among those who continue to use drugs. Due to changes in the availability of drug testing, the total number of drug tests and the number of days between tests conducted varied significantly from jurisdiction to jurisdiction. Overall, the typical HIDTA offender was drug tested once every 37 days while he/she was in treatment. The mean number of days between tests varied from a low of 13 days to a high of 70 days.

Graduated Sanction Implementation. Each jurisdiction we reviewed had a different graduated sanction protocol, including both judicial and administrative systems. Overall, jurisdictions had difficulty responding to the first, second, and third positive drug tests using progressively more stringent sanctions. It appears that neither certainty (of response) nor progressiveness (of response) have been implemented at the test sites.

The Impact of the HIDTA Model on Offending

The average re-arrest rate for a new offense is 11 percent at a 6-month follow-up and 16 percent at the 12-month follow-up (from intake). At the twelve-month follow-up, there is significant inter-jurisdictional variation in arrest rates, from a low of 6 percent to a high of 32 percent.

Offenders were typically arrested for drug offenses including possession, distribution or possession with intent to distribute. Based on our review of the previous patterns of offending among HIDTA offenders, the overall predicted re-arrest rate for these offenders is 52 percent. This represents a 70 percent reduction from the base rate (52% vs. 16% re-arrested). Estimates of the size of the recidivism reduction effect of the HIDTA model varied considerably from jurisdiction to jurisdiction, from a low of 33 percent to a high of 90 percent. Small sample sizes for many jurisdictions, in conjunction with the use of a pre-post non-experimental design measure impact, are two significant limitations to the study to consider when examining the “impact” findings presented here.

Implementation Barriers and Recommendations

During the planning, implementation, and evaluation stages of the HIDTA seamless system three key components of the system were identified as needing to be addressed in order to successfully implement the current and future systemic case management systems. Specifically, the need to appropriately target the needs and risks of offenders and identify what stage in their addictions and criminal career they are in, so as to adequately meet their treatment and other needs. Second, the need to offer various types of high quality treatment programs and phases to address specific needs and to promote longer treatment stays. Need to offer treatment in a convenient and safe place as a team, for example on location at a parole and probation joint run by supervision and treatment staff. Understand that treatment is a process not an episode and that more than one treatment program or stay may be needed. Important to address whole needs of offender and to prepare the offender that behavior changes are needed from them. Third, need to develop and consistently administer joint responses to noncompliance in a swift and certain way. To continue the impact, more attention is needed on providing a more rigorous application of the sanction and reward model as well as increasing the frequency of testing. The model requires treatment, testing, and sanctions to be equal partners in the coerced model. The HIDTA approach has primarily focused on treatment retention—more attention is needed to those components that are effective in addressing the more problematic offenders who are less resistant to treatment. Specifically, new efforts are needed in the areas of sanctions and rewards. The HIDTA sites could not have built the continuum of care or the seamless system with the assistance of funds from the Office of National Drug Control Policy. The gains—in terms of reducing offending rates among hard-core, active offenders—are likely as long as the treatment services continue to exist.

Future Analyses: The Need for an Experimental Design

Although these initial findings are promising, we must emphasize that they are preliminary, non-experimental and in need of further review. With such small sample sizes and without a control group(s) of non-HIDTA offenders, it is certainly premature to claim that participation in the HIDTA program was the primary factor explaining these positive outcomes. Future analyses stress the importance of using a controlled experiment.

Implications

The present study has a number of potential implications for theory, research and policy in the area of drug use and criminal behavior. First, it does appear that the “boundaryless system” concept has merit, especially when the target population is the hard-core drug user. Second, it is certainly possible that the age of the offender, in conjunction with the extent of the offender’s addiction and criminal career path to placement in the HIDTA program, may be at least partially responsible for the findings reported here. Perhaps older addicts are at the state in their lives where a comprehensive treatment and control program is actually somewhat desirable. Third, despite the potential “readiness for change among older, hard-core drug users, we suspect that coerced treatment is still necessary. Finally, it is our view that perhaps the most difficult “balancing act” for treatment and control staff is in the area of drug testing. The results reported here suggest that it is actually tolerance – rather than sanctions – that result in two important, intermediate outcomes: (1) length of stay; and (2) completion of treatment.

Introduction and Overview

The following report provides a detailed examination of the development, implementation and initial impact of the Washington/Baltimore High Intensity Drug Trafficking Areas (HIDTA) Model, based on a multi-site analysis of the program. The HIDTA Model represents an excellent example of the type of intra- and inter-system collaboration that most experts agree is critical to the success of drug treatment and control strategies in this country (Taxman, 2001, Taxman & Bouffard, 2000). At its core, the HIDTA Model represents a unique collaboration between agencies and organizations responsible for the *provision* of drug treatment services and the agencies and organizations responsible for the *community control* of offenders.

The report begins by providing an overview of the empirical evidence supporting the key elements of the HIDTA seamless system of drug treatment and control. The HIDTA Model is then described, focusing on the following four program elements:

1. continuum of care;
2. offender supervision strategies;
3. drug testing protocols; and,
4. compliance measures/graduated sanctions

In the next section of the report, the evaluation research strategy employed in this multi-site review is described, highlighting key decisions regarding data sources, operationalization of variables, design type and analytic framework. The findings section of the report includes an assessment of both level of program implementation and the impact of the HIDTA Model on offender behavior. The report concludes with a discussion of both the promise and pitfalls inherent in any intervention strategy, based on intersystem collaboration.

1. The Link Between Drug Treatment and Offender Control: A Review of the Research

In 2000, nearly 6.5 million people were under some form of correctional control in this country. About seventy (70) percent of our correctional population was under community supervision, while thirty (30) percent were in prison or jail (Bureau of Justice Statistics, 2001). It is conservatively estimated that over half of these offenders have significant substance abuse problems (Drug Policy Strategies, 1997), underscoring the link between addiction careers and criminal careers (Anglin & Hser, 1990). Among state prisoners, it is estimated that 83.9% of the offenders released from prison in 1999 were alcohol or drug involved at the time of the offense (Bureau of Justice Statistics, 2000). Among the state probation populations, the proportion of offenders who successfully complete their supervision has dropped from seventy (70) percent to sixty (60) percent in the past decade, due in large part to offenders' failure to abide by the conditions of their release related to abstinence from drug/alcohol use and/or participation in treatment (Bureau of Justice Statistics, 2000). Probation and parole "failures" are being incarcerated for their continued involvement in drug use and/or related criminal behavior at an alarming rate: in 1999 alone, fourteen (14) percent of the probation population (244,700) and forty two (42) percent of the parole population (173,800) were returned/sent to prison for a rule violation and/or a new offense (Bureau of Justice Statistics, 2001).

Since incarcerating and reincarcerating drug involved offenders can best be described as lifestyle "interruption" rather than lifestyle "change," it certainly makes sense to consider alternative strategies aimed at the cessation of both criminal and addiction careers. Given these dual concerns, a course of action focusing on the provision of a full range of treatment services

within institutional and community correctional settings appears to be the most obvious course of action.

Several empirical studies have illustrated the positive impact of drug treatment services on offender criminal behavior and drug use (Simpson, Joe & Brown 1997; Lipton, 1995; Taxman, 1998; Simpson, Wexler & Inciardi, 1999). Specifically, these studies demonstrate that offenders participating in drug treatment services are less likely to be rearrested or return to jail or prison than similar offenders who are not participating in drug treatment services.

Participation in treatment services not only contributes to reductions in the incidence of criminal behavior but also to increase in the overall length of crime-free time for offenders. Taxman and Spinner (1997), in their study of offenders who participated in a jail-based treatment program that included a continuum of care, found that 38.5% of treatment participants were rearrested within 24 months after release from jail compared to 48.7 % of the comparison group.

Additionally, the average offender participating in jail and community treatment took an average of 282 days to be rearrested compared to 201 days for the comparison group, an almost three month difference.

Substance abuse treatment services, however, are not always available to the criminal justice offender (Duffee & Carlson, 1996; Drug Policy Strategies, 1997) with less than fifteen (15) percent of offenders receiving some type of service. This practice continues although many researchers, policy-makers, and practitioners have recognized the potential effectiveness of drug abuse treatment in reducing recidivism among offenders (National Research Council, 2002, Peyton & Gossweiler, 2000; Anglin & Hser, 1990; Gerstein et al., 1994; Hubbard et al., 1989; Leukefeld & Tims, 1988, 1990; Lipton, 1995; Petersilia & Turner, 1993; Visher, 1990). It appears that the current organization and structure of the provision of services hinder the delivery of effective drug treatment (Harrell et al., 2002; Schlesinger & Dorwart, 1993; Duffee &

Carlson, 1996), particularly for the criminal justice offender (Duffee & Carlson, 1996; Falkin, 1993; Scarpitti, Inciardi & Martin, 1994; Wexler, Lipton & Johnson, 1988). In addition, the prevailing view by criminal justice agents that offenders are undeserving of treatment and that drug treatment should not be an integral part of the supervision sentence further impedes the development of collaborative efforts between supervision agents and drug treatment service providers.

For a client on criminal justice supervision required to participate in substance abuse treatment services, collaboration between treatment and control is critical for a variety of reasons. First, the leverage of the criminal justice system can be an important means of reducing treatment dropouts by establishing credible punitive contingencies. Second, supervision and monitoring can augment treatment by enhancing treatment goals and pursuing long-term outcomes. Finally, the use of criminal justice sanctions for offenders has been evaluated and recent results from a drug court evaluation in *Washington, DC* demonstrate that offenders who receive sanctions are four times less likely to continue drug use than typical supervision clients who do not receive sanctions (Harrell & Cavanaugh, 1996). The question is: how do we utilize the leverage of the criminal justice system in a manner that supports rather than subverts - treatment goals?

It is within this context that we can examine the results of recent reviews of community corrections programs that attempt to address both the treatment and control needs of offenders. For example, the evaluation research on intensive probation and parole supervision suggests that intensive supervision programs that emphasize the surveillance and control features of community supervision are not as effective as programs that attempt to balance offender treatment and control (see, e.g., Byrne, Lurigio & Baird, 1989; Petersilia & Turner, 1993). A similar pattern of findings is found in the reviews of the evaluation research on boot camps (see

e.g., MacKenzie & Souryal, 1994; Cowles, Castellano & Gransky, 1995), and day reporting centers (see e.g., Parent et al., 1995).

Despite these findings, program developers often lament the many difficulties associated with providing treatment to offenders, particularly drug users under community supervision. First, drug users often have a number of problems related to physical health and/or mental health that make “treatment” planning much more difficult. In most instances, it should be recognized that drug users are “multiple problem” offenders with a variety of treatment needs. Unless a comprehensive treatment assessment strategy is developed, it is likely that these offenders will “fail” in drug treatment. Second, resource constraints often limit drug treatment *availability* (resulting in inappropriate treatment placements) having an adverse effect on treatment *quality*. A number of recent reviews of the drug treatment literature have documented such problems as inadequate service levels (Dennis, 1990), the use of inappropriate services (Andrews et al., 1990a,b), the short duration of treatment programs (Pendergast et al., 1994), lack of staff training (Gustafon, 1991), and lack of essential program components (Gendreau, 1996). Any discussion of the effectiveness of drug treatment must begin by offering the following caveat: both treatment quantity and treatment quality must be improved in most jurisdictions *before* an impact evaluation can be conducted.

Finally, program developers’ ability to argue successfully for additional treatment resources is undermined by the dearth of experimental research on this topic (see e.g., National Research Council, 2002; Sherman et al., 1997). Evaluations conducted to date simply do *not* provide answers to the effectiveness questions most frequently raised by governmental officials and funding agencies. Indeed, the commonly cited finding of “no significant difference” in recidivism and/or substance abuse is likely due to research design flaws, resulting in such

problems as low statistical power, small sample sizes, lack of treatment integrity, and/or poor implementation of treatment procedures.

2. The HIDTA Model

Case management has been promoted as a critical component of any treatment system. It involves outreach, assessment, case planning, monitoring, reassessment, coordination, treatment planning, brokering services, treatment monitoring, discharge planning, advocacy, and/or clinical interventions (Anglin et al., 1996; Martin & Inciardi, 1996; Metja et al., 1994). The context and nature of case management practices varies considerably (Anglin et al., 1996) with tremendous uncertainty as to the actual functions performed by case managers (Shwartz et al., 1997). A series of studies on the effectiveness of case management have generated inconclusive and occasionally negative findings (e.g., Anglin et al., 1996; Martin, Inciardi, Scarpitti & Nielsen, in press; Taxman et al., 1997), due in part to the large variance in services rendered under the category of "case management." As it is most often practiced, case management relies on the individual manager to make informed decisions and scramble for the needed resources and services. Unfortunately, the case manager typically lacks the authority and resources to handle all pertinent decisions about a client.

In 1994, U.S. Congress established the Washington/Baltimore HIDTA (High Intensity Drug Trafficking Area) with the mixed responsibility for addressing the demand and supply of drugs. The HIDTA operates as part of the Office of National Drug Control Policy (ONDCP); this HIDTA is the only one responsible for the demand side as well as supply side of the drug control problem. A main objective of the ONDCP demonstration project was to redefine the relationship between the criminal justice and treatment systems from one based on the brokerage of services (case management) to one defined by rationing and triage (*systemic* case management) of scarce treatment resources. Specifically, under the brokerage service delivery model, the criminal

justice system brokered treatment services from the treatment system under the assumption that the treatment system had unlimited resources. By brokering treatment services in this way, the criminal justice and treatment systems offered separate programs and services, and maintained separate budgets. Under this model, the criminal justice system assumed no supervisory role while the offender was in treatment.

Under the rationing/triage service delivery model or seamless system, however, service integration defines the relationship between the criminal justice and treatment systems. Roles are specifically defined for criminal justice and treatment staff members, as too are jointly identified goals for offenders under supervision participating in treatment. Joint decisions regarding treatment selection, placement, monitoring, responses to positive drug tests, and discharge are predetermined by the supervision agent and treatment provider and services focusing specifically on offender outcomes are offered by both systems. Like many system reform efforts, systemic case management provides a structure to ensure that critical functions are performed by removing the barriers of coordination and having policy makers restructure roles and functions of staff to deliver integrated services. Treatment and criminal justice agencies function as a single entity rather than two separate units attempting to “coordinate” fragmented services and constantly struggling over who “controls” decision-making regarding the offender. The key is that policy makers have decided on core service units, allocated the appropriate resources, and set standards of care. By doing so, the role of treatment and supervision staff is to execute these standards. In the seamless system, the case manager is empowered as a member of the team with resources accessible to meet the *primary* needs of the client. Based on research in the treatment and supervision field, the components of the seamless system have been identified as affecting everyday decisions in the case management of clients throughout the various supervision and treatment stages including referral, placement, transition,

and discharge. The HIDTA seamless system includes the following components: (1) continuum of care, (2) supervision, (3) urinalysis testing, and (4) compliance measures and graduated sanctions. Each of the four key system elements is described below:

a. Continuum of Care. Research continues to demonstrate that length of time in treatment is influential in determining positive outcomes (Condelli & Hubbard, 1994; Hubbard et al., 1989; Simpson et al., 1997a). With the tendency in the treatment field to provide short-term services (Etheridge et al., 1997), the continuum of care requires that the offender participate in two levels of care—typically a more intense service followed by aftercare or counseling. The concept of a continuum is to move the client through the treatment delivery system consistent with his/her progress. Underlying the concept of a continuum is that treatment placement decisions should be affected by the offender's risk level to determine the amount of control and structure needed to augment treatment and criminal justice outcomes (Andrews et al., 1990a,b). For example, higher risk offenders may need a residential setting for six months because of the propensity to engage in criminal activity. The residential setting provides external controls on the offenders' behavior by limiting the amount of unsupervised time. As the offender demonstrates progress and personal development, he or she is moved gradually to less restrictive and more therapeutic services. The general model implemented as part of the HIDTA program include:

Residential Care followed by Intensive Outpatient Services/Outpatient Services. The model focuses on long-term residential treatment to stabilize offenders as they are achieving early stages of recovery. The residential treatment is a critical component of assisting the offender in achieving an acceptance and responsibility for recovery. Residential treatment furnishes the offender with the necessary skills to achieve sobriety from drugs (and alcohol) while beginning to develop a community plan to continue the sobriety. Long-term residential

treatment is usually four to nine months with most programs lasting six months in duration. Offenders continue in community treatment after release from the residential facility as they move through the different stages of recovery.

Intermediate Care followed by Outpatient Services. In this model, the offender is placed in a 28-day treatment program and then in a six-month outpatient program. The program within the intermediate care usually focuses on treatment readiness and preparation for change in the community. The goal of the 28-day residential program is to prepare the offender for change by using a variety of psychosocial educational modules and to begin the preparation for return to the community. Part of the discharge planning is to develop action plans that can guide the offender to change his/her behavior in the community. This model is being implemented in Montgomery County Maryland. In the District of Columbia, the Assessment Orientation Center (AOC) provides an intermediate care environment to emphasize developing the offender's motivation to change by focusing on pre-contemplation and contemplation phases of recovery. The AOC uses the period of time to assess and diagnosis the offender to determine appropriate placement in the community (e.g., residential treatment, intensive outpatient, outpatient, etc.).

Intensive Outpatient programming followed by Outpatient Services/Aftercare. In this model, the offender participates in intensive community programming for 6 to 9 months followed by six months of outpatient programming. The intensive outpatient programming usually consists of 9 to 20 hours of clinical services per week as well as self-help groups. The clinical services tend to use cognitive behavioral models that emphasize skills development, cognitive processing, and relapse prevention. The orientation emphasizes recovery in the community by focusing on prosaic values of employment, schooling, adherence to conditions of release, and community values.

Jail-Based Programming followed by Outpatient Services. Many offenders are in jail prior to release to the community. Incarceration provides an opportunity to begin the recovery process with a focus on continued treatment after release from the facility. Jail based programming includes cognitive skill development and relapse prevention as the two treatment strategies to address the offender's commitment to recovery. Jail based programming usually runs three to six months in duration and the emphasis is on maintaining the offender in treatment in the community after release. In some jail-based programs (after release from jail), offenders are placed in work release programs after release from the jail where treatment services are continued. In such cases, the work release program emphasizes work ethic and employment as part of the recovery process.

b. Supervision. Monitoring and oversight are vital to the management of offenders in the community and remains the primary component of supervision services. Supervision facilitates the treatment process by enforcing treatment conditions, and verifying and validating the progress of the client. Essentially, supervision consists of 1) *case management* (including collateral contacts to identify potential problems in the community), 2) *face-to-face contacts* (to observe and discuss treatment progress and compliance with general court conditions), and 3) *changes in supervision and services based on progress*. It is anticipated that the level of supervision provided to HIDTA offenders will be more intensive than past practice, particularly at the outset of the program.

c. Urinalysis Testing. Urinalysis testing serves both a therapeutic and monitoring function. The technology allows for immediate confirmation of the offenders' continued abstinence from substance use or the continued use. The frequency of drug testing can be varied depending on the behavior of the offender. Thus, it is a popular treatment and supervision tool to monitor offender compliance (Visher, 1990; Wish & Gropper, 1990). Since drug testing is used by both systems, it is

important that the drug testing information be shared and used to support mutual treatment and public safety goals.

d. Compliance Measures and Graduated Sanctions. Both treatment and supervision agencies share a common problem of compliance with program requirements. Simpson et al., (1997b) report that over half of the clients do not complete drug treatment programs and Taxman and Byrne (1994) estimate that at least half of the offenders do not comply with basic supervision requirements. Not surprisingly, noncompliance with probation requirements constitutes one of the main reasons for new prison admissions each year. Of course, the use and application of sanctioning (or the leverage of the criminal justice system) tends to vary considerably in practice, in both the treatment and criminal justice arenas. Recent advancements have promoted the use of behavior modification approaches, referred to as graduated sanctions in the criminal justice literature, to provide swift, certain, and appropriate responses to compliance problems (Harrell et al., 2002; Harrell & Cavanaugh, 1996; Kleiman, 1997). Similar to contingency management, graduated sanctions hold clients accountable for their behavior through a series of known consequences to common non-compliant behavior. The responses are set at gradations where more punitive and stringent sanctions are imposed with increased and continued non-compliance. In a recent evaluation of the DC Superior Drug Court, graduated sanctioned clients were four times *less* likely to test positive for drugs than when no sanctions were employed (Harrell & Cavanaugh, 1996). These findings provide theoretical support for the use of accountability measures to affect client behavior change. To the extent that graduated sanctions affect compliance, it may be possible to significantly reduce the single largest source of new prison admissions: the noncompliant offender on probation or parole.

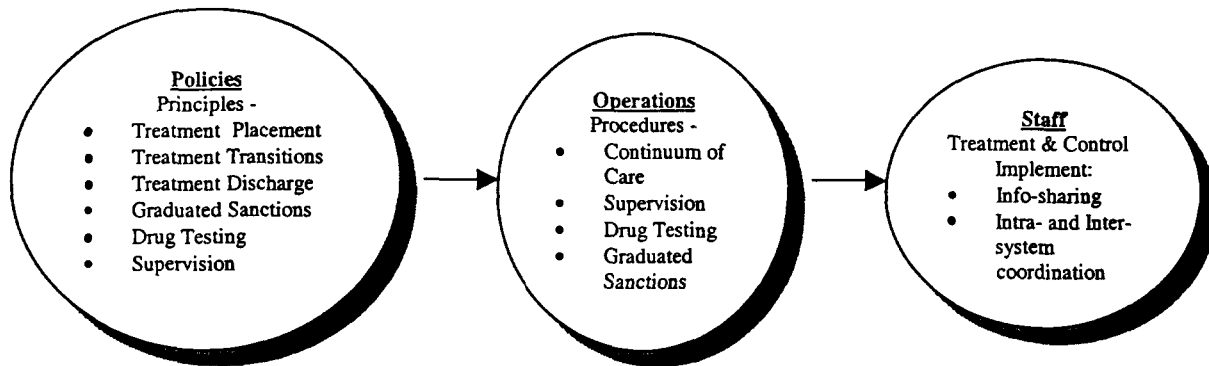
3. The HIDTA Demonstration Project

The Office of National Drug Control Policy (ONDCP) provides for regional approaches to drug problems, primarily drug trafficking issues. Most of the HIDTAs are involved in law enforcement specific activities. The Washington-Baltimore corridor was designated as a special HIDTA in 1994 by the ONDCP (Lee Brown was the Director at this time). ONDCP funded the HIDTA initiative to address both demand and supply issues. On the *demand* side, the goal was to improve the service delivery system for treating chronic substance abusing offenders. Each of the 12 participating jurisdictions (Virginia: Alexandria City, Arlington County, Fairfax/Falls Church, Loudoun County, Prince William County; Maryland: Baltimore City, Baltimore County, Charles County, Howard County, Montgomery County, Prince William County, and the District of Columbia) developed a seamless system tailored to their own socio-legal environment with the system reforms consistent with the core components, as shown in the following diagram and system model. Each jurisdiction has developed the supporting policies and procedures to ensure that the seamless system is implemented for chronic offenders in available treatment services. The HIDTA *seamless system* approach is characterized by the development of policies and practices that span treatment and criminal justice organizational boundaries. It is our view that this type of boundary spanning is the single most important feature of the HIDTA Model examined in this report.

Diagram 1 below illustrates the model to implement the policy based framework for the seamless system. This approach must include policies that support the four main domains: drug testing, continuum of care, supervision services, and graduated sanctions. All four areas require the support of management, and main changes in practice in the operating agencies. Additionally, the requirement that the approach span by multiple agencies to ensure the rationing/triage approach

requires that policies should be developed and put in place to ensure a change in the daily operations. In order for the model to be developed and implemented, policies must be developed and supported by procedures. The line staff will then be clear as to the new operational procedures and the working relationship among the different agencies.

Diagram 1: The HIDTA Model



4. Data and Method

Twelve separate jurisdictions agreed to participate in this evaluation, including six Maryland sites (Baltimore City, Baltimore County, Charles County, Howard County, Montgomery County, and Prince George’s County), five Virginia sites (Alexandria City, Arlington County, Fairfax County, Prince William County and Loudoun County), and the District of Columbia. Data were collected at each of these twelve sites on the total population of offenders admitted to the HIDTA program in 1997 (N=1,216). As Table 1 demonstrates, the size of the target population varied across the twelve sites, from a low of 29 referrals in Baltimore County during 1997 to a high of 545 HIDTA referrals in Baltimore City. Overall, 17.5 % of the offenders came into the system in January through March 1997, 39% in April through June, 24% from July through September, and 20% from October through December 1997. The variation in flow had to do with availability of funds from ONDCP to the site.

Table 1. Twelve HIDTA Sites and Size

Site	Target Cohort Size
1. Alexandria City	58
2. Arlington County	59
3. Fairfax County	36
4. Prince William County	28
5. Loudoun County	22
6. Baltimore City	545
7. Baltimore County	29
8. Howard County	37
9. Charles County	44
10. Montgomery County	53
11. Prince George's County	66
12. Washington, DC	276
TOTAL:	1,216

It should be noted at this point that both case flow and the total number of HIDTA participants identified at each test site were likely affected by the availability of funding for this project. Stated simply, there were many more HIDTA-eligible offenders at each site than funded treatment openings. Sites with a large number of participants (e.g., Baltimore City) received significantly more HIDTA funding than other sites, which allowed them to screen more offenders into the program. Unfortunately, there is no mechanism available to estimate the actual size of the 1997 HIDTA-eligible population across these twelve jurisdictions. For this reason, it is accurate to describe our population of 1997 HIDTA participants as a cohort, representing a subgroup of all HIDTA-eligible offenders in these jurisdictions.

Although a number of factors affected the size of the target population identified as HIDTA-eligible at each site, the HIDTA program's goal was to identify each jurisdiction's most difficult offender population: *hard-core drug-involved offenders*. At minimum, the HIDTA-eligible offender is a drug user who has been involved in the criminal justice system for several

years. However, since the final decision on eligibility criteria was left up to the individual jurisdiction, it is not surprising that there is considerable inter-jurisdictional variation in the instant offense, criminal histories, and drug use patterns of the target population identified here. For each offender identified as HIDTA-eligible, data were collected to document the offender's movement through the "seamless system" described earlier in this report. Regardless of the offender's status in the criminal justice system at the time of intake (i.e., pretrial release, probation, parole), data were collected on the following: (1) demographic and criminal history, (2) treatment placement and movement through treatment, (3) criminal justice supervision and services, (4) drug testing results, and (5) the use of graduated sanctions by either the treatment agency or the criminal justice agency. The University of Maryland has developed an automated tracking database (HATS) that allows criminal justice and treatment agencies to enter and share offender and client information. This information includes progress across various organizational networks while maintaining all of the federal protections for confidentiality. The integration of records from treatment providers and criminal justice agency providers is critical to assessing the impact of the HIDTA Model on the offenders included in this study. It could be argued that the process of *creating* this database facilitated the sharing of information both within and across systems. Because line staff at each jurisdiction knew that these data were being collected, it is also possible that data quality improved during the course of the study. While evaluators are always on the lookout for potential Hawthorn effects, our research design choice precludes a full discussion of this issue here.

The present study was conducted using a simple pre-post, non-experimental design. The pre-post design choice reflects our decision to provide *each* jurisdiction with an initial review of the implementation and impact of the HIDTA Model. While we recognize (and discuss) the limitations inherent in this design choice, it should be noted that based on our assessment of

implementation level, four of these twelve sites have been selected for participation in a separate, multi-site randomized field experiment (Baltimore County, Montgomery County, Prince William County and Alexandria City). One of the problems with field experiments conducted in the past by criminal justice researchers is that they often jump the gun, attempting to evaluate the impact of a program before it has been fully implemented. By using a non-experimental design to conduct our initial review, we can provide preliminary outcome data to jurisdictions while focusing our evaluation resources on the critical question of level of implementation. To the extent that we can identify an initial link between the level of implementation of the HIDTA Model and lower offending rates (our impact measure), there is further justification for providing a more comprehensive, randomized field experiment on the subgroup of full implementation sites. Parenthetically, this is the strategy recommended in a recent review of the research on drug treatment in criminal justice settings (National Research Council, 2002).

5. A Profile of HIDTA Participants

The HIDTA Model has been designed to target hard-core, substance abusing offenders who are both challenging clients for treatment providers and challenging offenders for community supervision agents. Table 2 provides a profile of the HIDTA offender, utilizing data collected on the 1,216 offenders who were identified as HIDTA participants across the twelve jurisdictions included in our review. While there is certainly jurisdiction-specific variation in several aspects of this profile (see Table 3), it is clear that the program has targeted the hard-core drug user.

The HIDTA offender was most likely to be an African-American male in his mid-thirties, who was not employed at the time of his arrest. The typical offender had an average of ten prior arrests and five prior convictions, with at least one prior period of incarceration. Further, examination of the criminal careers of these offenders underscores the fact that they have been

criminally active for several years: the typical offender averaged a little over one arrest per year for the past nine years. These offenders are currently in the criminal justice system because of their drug problem. Nearly 45% of these offenders had a drug charge with half of the charges involving distribution or possession with intent to distribute. It appears that the typical HIDTA offender is a low-level drug dealer who deals to support his/her addiction to drugs. The drug of choice for these offenders is either crack/cocaine (28.2%) or heroin (19.8%), consumed by smoking (39.2%), injection (12.7%), or some other oral means (17.4%) including inhalation. Although the treatment histories of HIDTA offenders are often unknown at the time of HIDTA intake, it appears that the majority of these offenders are addicts who have been in treatment before but who remain -- based on their own self-report response -- addicted to drugs. In fact, one of every three HIDTA offenders reported daily drug use at the time of their arrest. Clearly, there is significant overlap between the addiction careers and the criminal careers of these offenders (NOTE: see Table 3 and Appendix A for a site-specific profile of these offenders).

Table 2. Client Descriptive Statistics

Characteristic	Weighted Averages For All Jurisdictions Combined
MEAN AGE	36.0 years old
GENDER	80% male, 19% female, 1% unknown
ETHNICITY	62% African American, 27% Caucasian, 3% Latino, 1% Other, 8% unknown
MEAN NUMBER OF ADULT ARRESTS	9.9 arrests
MEAN NUMBER OF ADULT CONVICTIONS	5.6 convictions
EMPLOYMENT	25% employed, 74% unemployed, 2% unknown
PREVIOUS TREATMENT	39% previous treatment, 26% no previous treatment, 36% unknown
DRUG OF CHOICE	28.2% crack/cocaine, 19.8% heroin, 13.6% marijuana, 9.1% alcohol, 0.8% PCP, 0.8% other, 27.7% unknown
MODE OF CONSUMPTION	39.2% smoking, 12.7% injection, 9.9% oral, 7.5% inhalation, 2.9% other, 27.9% unknown
FREQUENCY OF SUBSTANCE USE	34.8% daily, 30.9% no past month use, 7.3% 1-3 times in past month, 6.6% 3-6 times per week, 3.5% 1-2 times per week, 0.8% not collected, 16.1% unknown
INSTANT ARREST	18% property crime, 17% CDS possession, 10% PWID CDS, 12% CDS distribution, 3% VOP, 5% assault/battery, 3% robbery, 5% other, 21% unknown

Table 3. Characteristics of 1997 HIDTA Sample

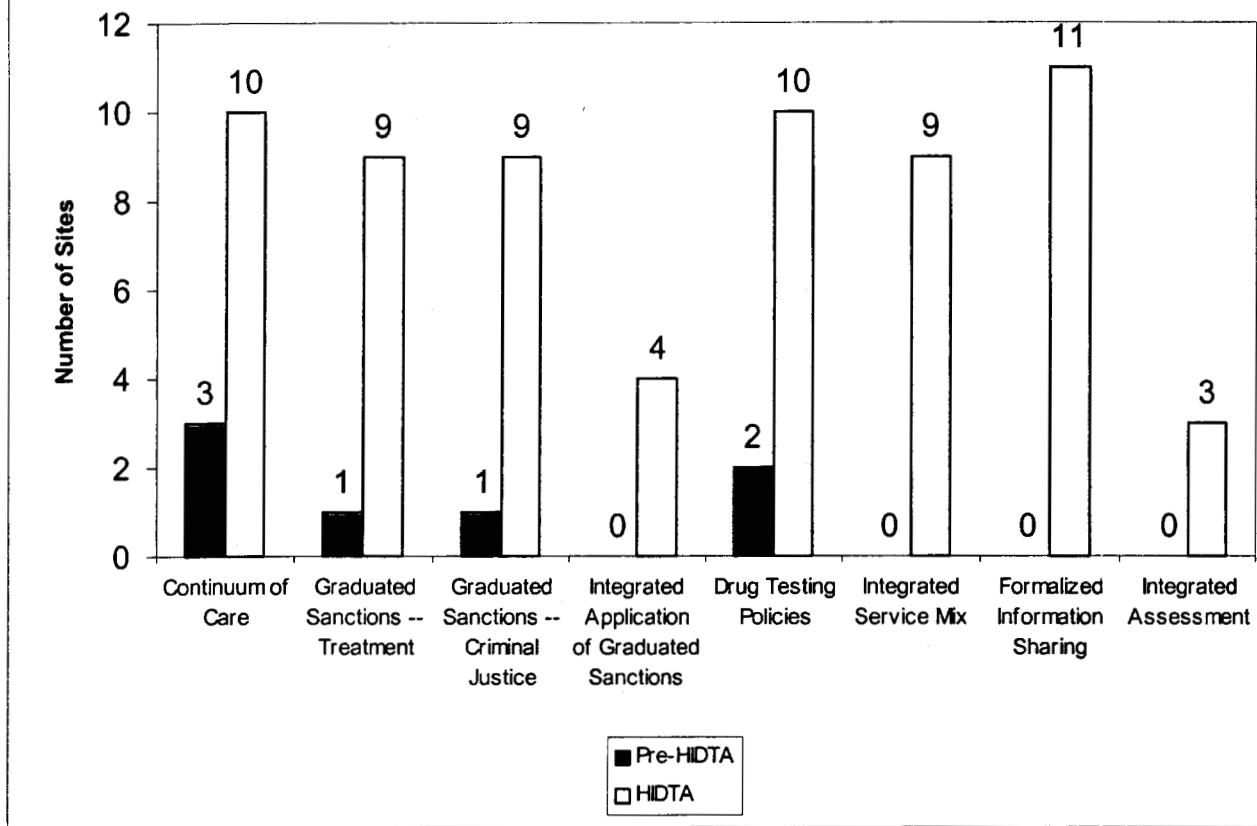
Site	Sample Size	Mean Age	% Male	% African-American	% Employed	% Drug Possession	Mean Arrests Per Year	Avg Yrs Criminally Active
1. Alexandria City	58	35	82%	77%	44%	31%	1.00	8.1
2. Arlington County	59	37	62%	70%	24%	7%	.81	9.6
3. Fairfax County	36	36	87%	49%	52%	14%	.76	8.8
4. Loudoun County	22	35	35%	45%	47%	33%	1.5	10.0
5. Prince William County	28	34	71%	36%	61%	39%	1.1	7.1
6. Baltimore City	545	35	71%	57%	17%	23%	1.5	11.4
7. Baltimore County	29	33	70%	36%	14%	17%	1.1	8.15
8. Charles County	44	34	85%	39%	10%	6%	.75	6.9
9. Howard County	37	34	98%	53%	27%	12%	.73	5.2
10. Montgomery County	53	32	92%	38%	48%	52%	1.1	10.0
11. Prince George's County	66	35	81%	72%	4%	20%	1.2	5.6
12. Washington, DC	276	40	81%	85%	20%	18%	1.3	9.7
TOTAL:	1,216	36	80%	62%	25%	11%	1.1	9.0

6. Assessing Implementation

The purpose of our implementation (or process) evaluation is two-fold: first, to determine the extent to which the HIDTA Model was implemented as designed; and second, to document changes in each jurisdiction's response to offenders during the pre-post comparison period. Focusing on the first of these two evaluation questions, we found that only four of the twelve jurisdictions were able to fully implement the three core components of the HIDTA Model: (1) continuum of care, (2) drug testing, and (3) graduated sanctions. The four sites were Alexandria City, Prince William County, Baltimore County and Montgomery County. Unfortunately, data collection problems precluded an overall assessment of the level of supervision provided to HIDTA participants. However, we have addressed this issue in our ongoing field experiment, which is targeting HIDTA participants at three of the four full implementation sites.

Figure 1 highlights important changes that have occurred during the pre-test/post-test period at the twelve HIDTA sites. In terms of the development of a continuum of care consistent with the HIDTA Model, three sites had actually developed such a continuum prior to the initiation of the HIDTA project. By the time of our post-test review, ten sites had such a system in place. Only two sites had drug-testing policies in place prior to the initiation of the HIDTA project, as compared to ten sites at the time of our post-test review. And finally, only one site had developed a system of graduated sanctions for either treatment providers or community correction agents prior to the start of the HIDTA project, as compared to nine sites following implementation of the HIDTA system. Although Figure 1 highlights the fact that there was considerably less progress in other related areas, it does appear that the HIDTA Model has fundamentally changed the way these jurisdictions respond to hard-core drug users. We expand on this finding below, focusing on three implementation areas: (1) continuum of care, (2) drug testing, and (3) graduated sanctions.

Figure 1. Progress on Implementing Seamless System Components



Area 1: Implementing Continuum of Care

Each jurisdiction used the funds from ONDCP to develop a continuum of care that fit within existing and available services. This allowed the grant funds to augment and enhance the existing system to provide a more effective system of care. Generally, the continuum of care had four major categories that focused on placing offenders in two consecutive treatment phases. It was recognized from the onset that some offenders may be placed in a lower level of care with the potential to adjust the intensity of treatment according to progress in the treatment continuum. For example, for relapsing offenders, the continuum allows for the ability to move offenders from a lower level of care (e.g., intensive outpatient, outpatient, etc.) to more intensive services such as residential treatment, jail

based treatment, etc. It also allows the use of less intensive services as offender's progress in their recovery (see Appendix A - Treatment/Criminal Justice Flow Chart Sample Seamless System).

Table 4 highlights the site-specific variations in the development of a comprehensive continuum of care system. Although our review has identified ten jurisdictions with a clearly defined continuum of care system in place, only one jurisdiction has developed a system that incorporates all four modalities of treatment (Montgomery County). This finding can be directly linked to the resource constraints faced by program developers at the other eleven sites.

Table 4. Continuum of Care Models in the HIDTA Sites

Models	Sites
Residential/Outpatient	Montgomery County, MD Fairfax County, VA Washington, DC Baltimore City, MD Arlington County, VA
Intensive Care Facility/Outpatient	Baltimore County, MD Washington DC Montgomery County, MD
Intensive Outpatient/Outpatient	Alexandria City, VA Fairfax County, VA Prince William County, VA Loudoun County, VA Montgomery County, MD Baltimore City, MD
Jail Based Treatment/Outpatient	Charles County, MD Howard County, MD Montgomery County, MD Prince George's County, MD Arlington County, VA Fairfax County, VA

The HIDTA protocol was designed to increase offenders length of time in treatment through participation in the continuum of care. To achieve this desired effect, the programs had to work on retention during the first phase, usually the most intensive component of the treatment experience. However, it was also recognized that part of the process involved the transition of offenders that were having difficulty in stabilizing their behavior in a less intensive component to a more intensive treatment experience. Therefore, completion reflects two

concepts: completion of the first phase or movement into another more appropriate treatment experience. The seamless system provides that protocol for the transition based on the offender's progress. The continuum is built on the notion that some clients need less intensive services as the second phase, some need more intensive services, and some can suffice with aftercare services of self-help groups or vocational education. That is, the system must function to move the offender into the appropriate level of care. In addition to determining the appropriate level of initial treatment, it is also critically important to assess the progress of the offender. This needs to be approached from a systemic perspective to determine whether more treatment is warranted and the type of treatment that is most appropriate at the time.

Table 5 illustrates key performance measures regarding the treatment component of the program. Since each jurisdiction has a different planned treatment continuum (as discussed in Appendix A), the patterns of length of stay vary differently. It should be noted that the completion rates for the first phase of treatment are higher than those reported in DATOS where forty (40) percent of the clients completed treatment similar types of treatment (Simpson, et al., 1997a,b). The average successful completion rate is sixty-four (64) percent based on the treatment literature, which is better than expected.

The HIDTA approach, which also focuses on treatment duration, retains the average offender in treatment longer than expected based on the industry norms. That is, the average outpatient program is generally 90 to 120 days. As shown in Table 5, the HIDTA protocol has served to increase this retention in treatment with an average of 208 days in treatment.

Table 5. Treatment Duration & Completion of First Phase of Treatment

SITE	% Still Active	% Complete	% Successful Completion*	Mean Length Stay In Tx (in Days)
Alexandria City	55	45	54	232
Arlington County	53	47	72	215
Fairfax/Falls Church	58	42	70	218
Loudoun	28	72	60	172
Prince William	62	38	63	265
District of Columbia	58	42	64	213
Baltimore City	54	46	61	195
Baltimore County	62	38	66	244
Charles	52	48	62	211
Howard	56	44	50	199
Montgomery	53	47	55	259
Prince George's	47	53	74	188
Overall	55	45	64	208

*Note that successful completion refers to the completion of the expected duration of treatment. Often criminal justice clients, due to their status, may not complete due to a change in legal status, movement across the legal spectrum, etc. Many offenders transition into other levels of service regardless of whether they complete the duration of a particular time frame in a given program. This varies depending on the jurisdictions and the continuum of care available in that jurisdiction.

The HIDTA protocol has two main features that affect the offender's duration in treatment. First, the protocol is designed to step treatment up or down based on progress. Even though an offender may not complete the expected duration of the treatment, the protocol overall serves to assist with transitioning issues. This is critical in adjusting the treatment protocol to the offender's progress as well as to the offender's legal status. For offenders in jail, release is often discretionary and may not correspond with the completion of a treatment program. And in the community, offenders may be required to attend treatment in jail or a special residential facility. Second, the issue regarding duration is that the continuum concept is designed to increase the overall length of participation in treatment programs for the benefit of stabilizing the offender and addressing recovery issues. Treatment duration is considered to be the best predictor of success—regardless of modality of program. The protocol works to maximize access to services and to increase the offender's length of stay in treatment.

Area 2: Implementing a System for Drug Testing Offenders

The HIDTA protocol targets the criminally active substance abuser under the control of the criminal justice system. The protocol involves drug testing the offender while the offender is actively involved in treatment. Drug testing provides an objective measure of whether the offender is continuing to abuse drugs while involved in treatment. Early in the HIDTA program, ONDCP made funds available to enhance drug testing around the region. During the first two cohorts of the HIDTA program, direct funding for drug testing was available. In 1997, funds were removed from the HIDTA budget for drug testing. Jurisdictions were asked to continue drug-testing offenders using available funds in their jurisdiction. Many jurisdictions implemented drug testing on various schedules based on the available funds from either the criminal justice or treatment systems. As level funding occurred, many of the programs attempted to maintain the following schedule through existing funds. Table 6 shows the 1998 Drug Testing Protocols.

Table 6. Drug Testing Protocols

Drug Testing Procedures (1998)	Sites
Random	Arlington County, VA
3 Times A Month	Alexandria City, VA Fairfax County, VA Howard County, MD
Weekly	Baltimore County, MD
Twice A Week	Loudoun County, VA Prince William County, VA Baltimore City, MD Charles County, MD Montgomery County, MD Prince George's, MD Washington, DC

From intake to treatment, approximately sixty-five (65) percent of the offenders do not test positive for illicit drugs (excluding alcohol). This is primarily due to the fact that the offenders

are under legal control that serves to suppress their use of illicit drugs. Of the thirty-five (35) percent that test positive for an illicit substance during this pre-treatment period, the drug of choice in the HIDTA jurisdictions based on drug test results are: cocaine/crack (11 percent); marijuana (6 percent); and heroin (5 percent). It should be noted that these drugs of choice are slightly different than the self-reported drug of choice where addicts tend to emphasize their use of cocaine/crack, heroin, and then marijuana. Table 7 shows the drug test results by jurisdiction.

Table 7. Drug Testing Results for HIDTA Jurisdictions

Site	Avg. % Testing Positive During Treatment	Average Number of Days Between Testing
Alexandria City	18%	20
Arlington County	20%	13
Fairfax County	19%	46
Loudoun	20%	21
Prince William	13%	14
District of Columbia	21%	29
Baltimore City	22%	49
Baltimore County	25%	32
Charles	07%	70
Howard	15%	63
Montgomery	15%	**
Prince George's	05%	26
Overall	18%	37

**Data were not available for Montgomery County in terms of number of days between testing.

Overall, the HIDTA sites are experiencing low rates of testing positive during the treatment period. The positive tests can be for any illicit drug (e.g., marijuana, cocaine/crack, etc.). The drug of choice during treatment tends to be marijuana.

Table 7 also illustrates the impact of the funding for testing on the frequency of testing. Most of the jurisdictions were unable to maintain their projected testing protocol due to changes in the availability of funds for drug testing. The impact is felt on the average percentage of offenders that test positive during the treatment regime. Research has shown that a more

constant and consistent pattern of testing offenders results in reduced positive test rates (Wish & Gropper, 1990).

Overall the testing illustrates that treatment contributes to a significant reduction in the test positive rate. The estimate of offenders testing positive at intake is thirty-five (35) percent. These results illustrate that treatment contributes to a forty-nine (49) percent decline in the test positive rate—from thirty-five (35) to eighteen (18) percent. It should also be noted that many offenders are more likely to continue to test positive for marijuana than other illicit drugs such as cocaine and heroin. The change in drug of choice also contributes to reduce non-drug use criminal behavior because the literature is less clear about the marijuana-crime nexus (as compared to the cocaine/crack/heroin nexus).

Area 3: Implementing a System of Sanctions and Rewards

The cornerstone of the HIDTA protocol is enhanced supervision and case management of the offender to include the use of sanctions and rewards to address offender compliance patterns. The consequence protocol was designed to be specific to each jurisdiction with the jurisdiction developing a protocol that is compatible with their socio-legal culture. This resulted in 12 different sanction protocols; some were judicially ordered and others were administrative in nature. The key components to the protocol are that the sanction/reward should be swift, certain, and progressive. Judicially ordered sanctions enhanced the authority of the supervision staff by the court recognizing authority.

In 1996, HIDTA sponsored a series of two-day training sessions on sanctions to allow the jurisdictions to develop their sanction/reward protocol. As expected, this is one of the most challenging parts of the process because it requires a basic refinement in the communication among treatment and criminal justice agencies. The sanction/reward protocol also moves the system from a discretionary response system to a structured decision-making system to meet the

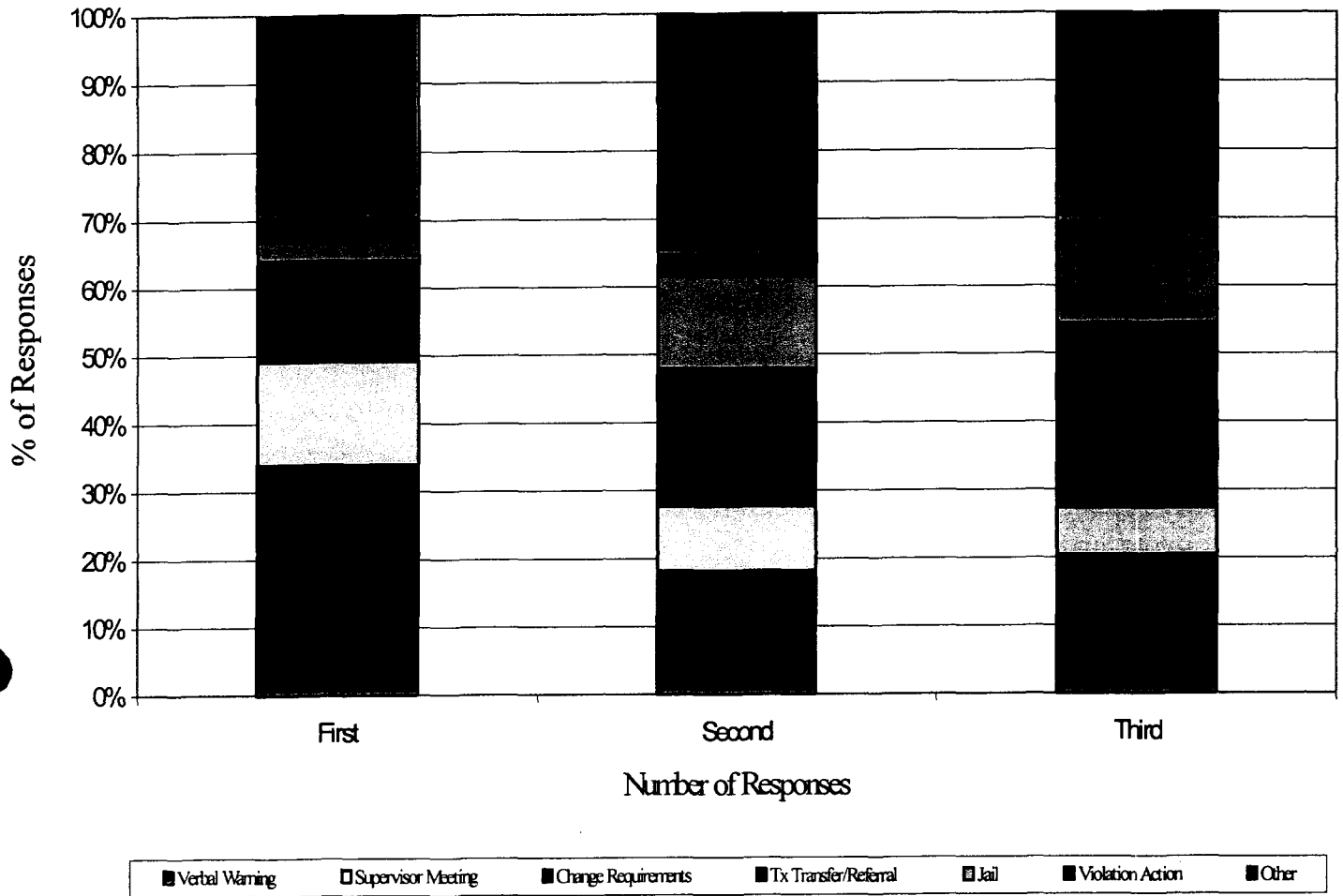
goals of reducing drug use and criminal behavior through a purposeful response to negative behavior. An advantage of the approach is that communication with the offender is more targeted and focused on outcomes. To facilitate the process, many jurisdictions developed a behavioral or sanctions contract, which provides a framework for communicating the negative behavior and expected consequences to the offender. This contract can incorporate both administrative and judicially ordered sanctions. Some jurisdictions incorporated the sanctions into the standard practice of treatment and supervision. At the end of the 1997 training session it was realized that more attention was needed to the development and implementation of the sanction protocol in large part due to philosophical differences between the treatment criminal justice personnel on the type of sanctions to be used. Similarly, a lack of consensus was also reported in the development of a reward structure.

Table 8. Graduated Sanctions Protocols

Graduated Sanctions (1997)	Sites That Implement These Sanctions
<u>Administrative Sanctions</u> First Positive Test: Face to Face Contact Increase Reporting Increase Drug Testing Second Positive Test: Supervisory Reprimand Self-Help Groups Report to Court Third Positive Test: Increase Drug Testing Intensify Treatment	Alexandria City, VA Arlington County, VA Fairfax County, VA Loudoun County, VA Prince William County, VA Baltimore County, MD Charles County, MD Howard County, MD
<u>Judicially Ordered Sanctions</u>	Washington, DC Montgomery County, MD Prince George's County, MD

Figure 2 illustrates that the sanction protocol needs further work in terms of the implementation. The exhibit shows that there is some progressive nature of the action—as the negative behavior continues, the type of responses is altered. Yet, it also shows that there is little variation across the first three positive drug tests. An examination of Table 8 illustrates that eight (8) of the twelve (12) jurisdictions are implementing administrative sanctions and three (3) jurisdictions are implementing judicial order sanctions and that the concepts of certain and progressives are not well implemented. Some jurisdictions like Alexandria City and Prince William, which developed strict policies and procedures, have translated into clearer practices. More attention in the other jurisdictions is needed on the development of their policies. Further, development is also needed on the training of staff (treatment and criminal justice), supervisors, and other interested parties. However, we should point out one important, unanticipated consequence of the *development* of graduated sanctions: increased tolerance by criminal justice decision-makers for multiple drug test failures. It may be that the reason HIDTA offenders are staying in treatment longer and completing treatment program levels more frequently is that early drug test failures (particularly for marijuana) are not being used as a reason to terminate the offender for treatment. In this regard, the National Council Research (2002: 8-3) recently concluded that “permanent abstinence may not be a realistic goal of any single round of treatment for heavy long-term users.”

Figure 2: All Jurisdictions Positive Drug Tests by Type of Response



7. The Impact of the HIDTA Model on Offending – A Preliminary Assessment

Much of the empirical research on the drug-crime connection focuses on understanding the *onset* of both an offender’s addiction career and his/her criminal career. Correction officials, however, are interested in the *cessation* of these often overlapping and likely casually connected “careers.” To this end, programs such as the one described here attempt to get offenders into treatment and, hopefully out of the criminal justice system. It is important to keep in mind that

this evaluation does not represent a test of a specific treatment modality (such as methedone for heroin addicts), but rather a general, system-wide orientation toward improving both treatment quantity and quality. Similarly, the HIDTA Model does not specify a particular supervision level, drug testing protocol, and/or graduated sanction system. Given the variations we have already documented in the development and implementation of the HIDTA Model across twelve jurisdictions, we anticipated much interjurisdictional variation in our primary outcome measure - the offending rates of hard-core drug users. However, we did *not* anticipate either the reduction in drug use during the post-test period documented in the previous section or the significant, overall reductions in arrest levels and offending rates we describe below. Why did these changes occur in drug use and offending? Perhaps the simplest answer is the most accurate: it is not a matter of specific *program* development - it is a matter of general *systems* development (Taxman & Bouffard, 2000).

The evaluation strategy involved a pre-post design that compares the actual reoffending rate of the offender with prior offending patterns. Table 9 shows the rearrest rates based on two different follow-up time periods: 6 and 12 months. The 12-month follow-up is cumulative to indicate any rearrest after the involvement in treatment for 12 months in the community. The average rearrest rate for a new offense is sixteen (16) percent although there is significant variation across the region ranging from six (6) to thirty-two (32) percent. Offenders who are rearrested tend to be rearrested for drug offenses including possession, distribution or possession with intent to distribute. Other common rearrest offenses are property crimes (e.g., theft, larceny, and shoplifting), robbery, assault, and technical violations.

Table 9. Comparison of Actual Rearrest Rate at 6 and 12 Month Follow-up Periods

Site	6 Month Arrest for New Crime (%)	12 Month Arrest for New Crime (%)
Alexandria City	8%	16%
Arlington County	3	16
Fairfax/Falls Church	17	32
Loudoun County	5	10
Prince William County	11	24
District of Columbia	10	22
Baltimore City	5	13
Baltimore County	3	30
Charles County	9	20
Howard County	11	**
Montgomery County	0	6
Prince George's County	6	11
Overall	11	16

**Due to problems with FBI records, no records were provided in this sample. The records are on order.

The evaluation is designed to examine the hypothesis about the impact of the HIDTA treatment protocol on rearrest rates. The base rate or the likelihood that offenders will be rearrested is derived from the average rate of offending for the offender. That is, given the high rate of offending for this cohort of substance abusing offenders, the researchers would have expected to find that fifty-two (52) percent of the offenders would have been rearrested during the follow-up period. Figure 3 illustrates that the HIDTA intervention has a different slope than the expected recidivism rate.

Table 9 illustrates that the average rearrest rate was sixteen (16) percent, compared to the expected fifty-two (52) percent rearrest rate. This is a seventy (70) percent reduction from the base rate, demonstrating that the HIDTA intervention likely affected the frequency of the offender offending in the different jurisdictions. It also appears to demonstrate the sustained effects of the HIDTA initiative, supporting the strength and utility of the HIDTA approach, and underscoring the apparent importance of treatment duration. The average offender is reported to have participated in 208 days of treatment or over six months in treatment; this is consistent with researchers that suggest longer duration in treatment as a tool to reduce criminal behavior and substance abuse.

Figure 3: HIDTA 12-Month Results vs. Base Rate of Rearrest

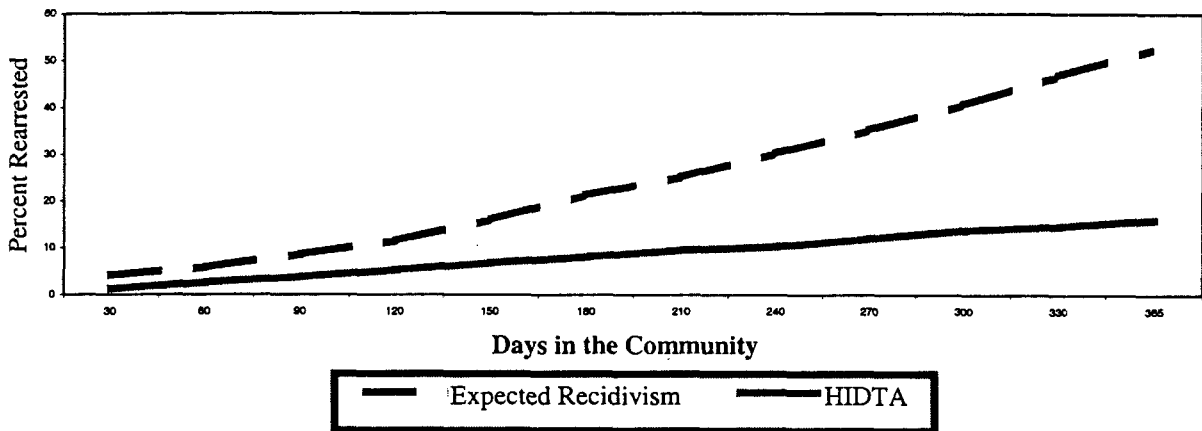


Table 10. Comparison of Base Rate with Participation in the W/B HIDTA Protocol

Site	Base Rate (Prior HIDTA TX)	HIDTA TX	Recidivism Reduction
Alexandria City	.47	.16	-67
Arlington County	.55	.16	-55
Fairfax/Falls Church	.50	.32	-33
Loudoun County	.50	.10	-80
Prince William County	.65	.24	-63
District of Columbia	.40	.22	-45
Baltimore City	.60	.13	-78
Baltimore County	.62	.30	-52
Charles County	.71	.20	-72
Howard County	.33	*	*
Montgomery County	.60	.06	-90
Prince George's County	.49	.11	-77
Overall	.53	.16	-70

*Records were only received for 1,027 offenders due to Y2K issues at the FBI. With the exception of Howard County, each other site had a representative sample of offenders.

Although these initial findings are promising, we must emphasize that they are preliminary, non-experimental and in need of further review. With such small sample sizes and without a control group(s) of non-HIDTA offenders, it is certainly premature to claim that participation in the HIDTA program was the primary factor explaining these *positive outcomes*. However, we are hopeful that these initial findings will be replicated in the separate, controlled experiment being conducted on this project (see e.g., Thanner & Taxman, under review).

Conclusion

As noted at the outset of this report, it is estimated that over half of the 6.5 million offenders under correctional control in this country during 2000 had a significant substance abuse problem. With only a few exceptions, strategies designed to address the drug problems of these offenders have failed, resulting in a seemingly endless cycle of offender movement from institutional to community and then back again. The HIDTA "Seamless

System” Model examined in this evaluation attempts to address this problem by focusing on the development of a coordinated, multi-system treatment and control strategy. It is this general, systemwide model that is the focus of both our process and impact evaluation. Rather than offering an assessment of a particular treatment modality (e.g., methadone maintenance programs) we are attempting to gauge the implementation and impact of a treatment/control system for all forms of drug addiction.

Our evaluation underscored both the difficulties inherent in a multi-jurisdictional systemwide change effort (see e.g., Taxman & Bouffard, 2000 for a more complete review) and the potential positive effects of this type of systemwide collaborative effort on the cessation of both the offenders’ addiction and criminal careers. Perhaps most important is our finding that HIDTA offenders remained in treatment longer (an average stay of 208 days in treatment) and had a higher than expected program completion rate (sixty-four [64] percent successfully completed treatment). The impact of these two basic changes in treatment provision on offender behavior are worth considering, despite the preliminary nature of the research: (1) HIDTA offenders had a forty-nine (49) percent reduction in the positive drug test rate; and (2) HIDTA offenders had a seventy (70) percent reduction in the likelihood of rearrest.

Implications

This study has important implications for theory, research and policy in the area of drug use and criminal behavior, despite the limitations of the research design strategy we have highlighted. In terms of theory, it appears that previous research may have focused too often about the onset of criminal and/or addiction careers; in the process important questions about the cessation of these dual (and often overlapping) careers have gone unanswered. This is an area that is currently being examined under the research on desistance. The lessons here for desistance research is the dual role of treatment and control that may potentially play a role in the

decision-making to make changes in the offender's life. The question is how much the model motivated offenders to change. This further research is needed to understand the issues related to treatment and control and how they are perceived by the offender.

This study has also offered an interesting approach to an often vexing problem for research scientists interested in conducting a controlled, randomized field experiment: How do you identify jurisdictions who have fully implemented the "treatment" being examined (in this case, the HIDTA Seamless System)? Far too often in the area of criminal justice, researchers have wasted time, money and other resources trying to conduct experiments on "failed" programs (in terms of implementation level, targeting strategies and sample size). To address this problem, we have conducted a fairly comprehensive implementation evaluation across twelve (12) separate jurisdictions in order to identify subgroup of sites that appear to be ready for a controlled field experiment. Since the twelve (12) jurisdictions are not only interested in implementation, but also impact, we have employed a less rigorous and less costly evaluation design to measure the preliminary effectiveness of this strategy across all sites. As a result of this design strategy, we have been able to identify three (3) jurisdictions that would fit our criteria for acceptable field experiment sites (see, e.g., Thanner & Taxman, under review), while still providing important, preliminary outcome data to all participating jurisdictions.

Finally, our research has some important potential policy implications. Contrary to the view of many observers, it is possible to develop effective intervention strategies for the hard-core drug users that comprise a significant proportion of the 6.5 million offenders under correctional control in this country. However, to be successful, our focus needs to move away from discussions of individual, offender-based change strategies (e.g., methadone maintenance for heroin addicts, cognitive restructuring for cocaine (crack) users, etc., and toward system-wide change strategies. In this view, it may be less important to think in terms of the effectiveness of

specific treatment modalities, and more important to think creatively and decisively about how to improve the quantity and quality of both criminal justice supervision and treatment service delivery systems. The HIDTA “Seamless System” Model evaluated in this report offers an excellent example of this type of intersystem cooperation and collaboration.

While we must resist the urge to focus too much attention to the positive (albeit preliminary) findings we report on the recidivism reduction effects of the HIDTA Model, it does appear that this approach has the potential for significant system-wide cost savings. In addition, an equally important implementation finding was that improvements in intra- and intro-system coordination and treatment resource availability resulted in noticeable increases in both treatment program completion rates and length of stay in treatment. It should be obvious to even the casual observer that you are not going to change a “lifetime” of addiction and criminality with any single, short-term strategy.

The fact that this is a coerced treatment strategy with compliance monitoring (via drug testing) and graduated sanctions for continued drug use should not be forgotten, because despite our comments at the outset of this section, the reality is that these offenders had to be forced to go to treatment and to remain in treatment for the duration of the program. However, it appears to us that one byproduct of the improved communication and information sharing between treatment providers and criminal justice professionals is an increased level of tolerance for drug test failures. It is certainly possible that offenders who tested positive in these jurisdictions were given multiple chances to stay in the program and therefore it is system response – rather than individual offender behavior – that offers the best explanation for why these hard-core drug users were able to stay in treatment longer and complete treatment programs at such a high rate. Finally, it is certainly possible that higher levels of tolerance for the continued drug use of long time addicts – particularly when the drug use is for less serious

drug use (i.e., marijuana vs. heroin) – represents an even more fundamental change: a growing goal consensus between treatment and control staff in such areas as the need for proper assessment, the importance of treatment protocols, and the recognition that the cessation of an offender's addiction career is not going to happen overnight. Stated simply, both treatment and control appear to now agree: long-term problems require long-term solutions.

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Appendix A Characteristics of the Sample Per Justification (1997)

	Alexandria City (%)	Arlington County (%)	Fairfax County (%)	Prince William County (%)	Loudoun County (%)	Baltimore City (%)	Baltimore County (%)	Howard County (%)	Charles County (%)	Montgomery County (%)	PG County (%)	Washington D.C. (%)
<u>Previous Treatment</u>												
Yes	45	41	53	84	88	17	53	27	11	14	32	32
No	28	20	26	3	4	57	19	18	8	28	61	29
Unknown	27	39	21	13	8	26	28	55	81	58	7	39
<u>Drug of Choice*</u>												
Alcohol	8	18	3	0	6	0	0	21	10	0	0	0
Crack/Cocaine	51	34	23	50	50	0	0	57	28	0	73	13
Heroin	2	28	15	0	10	0	0	14	34	0	7	40
Marijuana	37	14	8	50	20	0	0	0	15	0	14	13
PCP	0	1	2	0	3	0	0	0	0	0	0	0
Other	2	1	1	0	10	0	0	0	1	0	0	0
Unknown	2	5	49	0	7	100	100	7	16	100	7	33
<u>Mode of Consumption*</u>												
Injection	2	17	5	24	7	0	0	14	20	0	7	27
Smoking	79	47	33	46	63	0	0	29	31	0	73	13
Oral	8	18	5	9	10	0	0	14	9	0	0	0
Inhalation	0	3	3	15	0	0	0	29	18	0	7	13
Other	0	10	0	0	0	0	0	0	0	0	0	0
Unknown	11	5	49	7	20	100	100	14	22	100	13	47
<u>Frequency of Use*</u>												
No past month use	32	4	33	0	0	0	0	0	26	0	0	0
1-3 times in past month	22	2	9	0	0	0	0	0	2	0	0	0
1-2 times in past week	6	4	3	0	0	0	0	0	4	0	7	10
3-6 times in past week	3	17	3	0	10	0	0	0	4	7	0	10
Daily	8	71	20	100	47	0	0	21	36	17	93	28
Unknown	29	2	33	0	33	100	100	36	28	68	0	45
Not collected	0	0	0	0	0	0	0	36	0	0	0	0

	Alexandria City (%)	Arlington County (%)	Fairfax County (%)	Prince William County (%)	Loudoun County (%)	Baltimore City (%)	Baltimore County (%)	Howard County (%)	Charles County (%)	Montgomery County (%)	PG County (%)	Washington D.C. (%)
Instant Offense												
Assault/Battery	2	2	2	0	2	0	9	10	2	10	2	6
Auto Theft	0	2	1	0	0	3	1	1	1	0	1	0
Property Crimes	8	27	19	16	10	11	43	11	13	18	27	11
Distribution	22	11	30	13	10	6	1	13	1	0	10	17
Possession	31	7	14	39	33	23	17	12	6	52	20	18
PWID	9	7	3	0	4	37	3	3	2	2	33	17
Paraphernalia	4	0	1	0	2	0	0	0	0	0	0	0
Forgery/ Uttering	3	5	4	10	4	0	2	1	1	0	0	1
Probation/ Parole Violation	3	8	2	16	14	0	2	1	0	0	4	1
Prostitution	0	1	0	0	0	0	1	0	0	0	0	1
Rape/Sodomy	0	0	3	0	0	0	0	0	0	0	1	1
Robbery	4	6	1	0	0	0	3	0	2	0	0	7
Homicide/ Manslaughter	0	0	0	0	0	0	0	1	0	0	0	2
Weapons	1	0	1	0	0	0	0	0	1	2	1	2
Sexual Offense	0	0	1	0	2	0	1	1	0	0	0	0
Miscellaneous	3	4	7	3	12	6	3	3	3	10	3	5
Unknown	11	21	12	3	6	14	14	43	70	6	1	12

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	Alexandria City (%)	Arlington County (%)	Fairfax County (%)	Prince William County (%)	Loudoun County (%)	Baltimore City (%)	Baltimore County (%)	Howard County (%)	Charles County (%)	Montgomery County (%)	PG County (%)	Washington D.C. (%)
<u>Age</u>												
18-25	13	10	11	7	6	3	19	17	15	30	16	7
26-31	21	18	17	26	22	37	26	21	30	20	13	10
32-37	28	25	27	36	31	31	27	32	21	26	35	22
38-up	38	43	45	32	41	29	28	31	34	24	36	31
Mean Age	35	37	36	34	35	35	33	34	34	32	35	40
<u>Gender</u>												
Male	82	62	87	71	35	71	70	98	85	92	81	81
Female	18	32	13	29	65	29	29	1	15	8	19	18
Unknown	?	6	1	0	0	0	1	1	0	0	0	1
<u>Ethnicity</u>												
African American	77	70	49	36	45	57	36	53	39	38	72	85
Caucasian	9	18	46	48	47	14	56	39	58	24	10	2
Latino	1	5	2	0	2	0	0	1	0	16	13	3
Other	0	1	1	0	0	0	1	1	0	2	1	1
Unknown	13	6	2	16	6	29	7	6	3	20	4	10
<u># Adult Arrests</u>												
Mean	10	12	13	15	12	13	8	7	9	3	9	9
Median	8	8	10	11	7	12	6	6	6	2	9	7
Unknown	32	30	30	2	6	1	35	63	141	8	8	34
<u># Adult Convictions</u>												
Mean	7	7	8	9	10	6	4	4	4	2	4	5
Median	5	5	6	7	10	6	3	3	3	2	3	4
Unknown	33	37	31	2	6	1	47	75	143	7	9	49
<u>Employed</u>												
Yes	44	24	52	61	47	17	14	27	10	48	4	20
No	48	76	48	39	53	66	85	71	89	48	96	80
Unknown	8	0	0	0	0	17	1	2	1	4	0	0

TREATMENT/CRIMINAL JUSTICE FLOW CHART SAMPLE SEAMLESS SYSTEM

