

**Drug Treatment for Offenders:
Evidence-Based Criminal Justice and Treatment Practices**

Testimony:

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I am grateful for the opportunity to present the current state of drug treatment services for offenders to the Appropriations Subcommittee on Commerce, Justice, Science, and Related Agencies. I am a professor in the Administration of Justice Department at George Mason University, with expertise in health services for offender populations. In this time of rethinking our current policies and strategies to improve public safety and public health, evidence-based practices and treatments are a good place to start. . We can identify the components of effective programs and services for offenders, as well as how criminal justice agencies can facilitate a commitment to recovery and helping offenders become law-abiding citizens.

Our largest challenge is to provide sufficient capacity for quality programs and services in the *community* and to improve the skills of the workforce in both the addiction treatment and correctional fields. Reentry discussions have generally focused on the smallest pool of offenders—those leaving prison, a pool of nearly 800,000 offenders a year. Our public policy has neglected the greater portion of offender populations—those offenders “reentering” from jails (about 12 million if one includes pretrial offenders) and offenders in the community on probation supervision (around 5 million). This neglect has limited our prevention efforts, and increased the demand for prison space. An emphasis on the front end of pretrial and probation would improve our efforts to reduce the churning through the criminal justice system. Since an average of 40 percent of new intakes to prison are failures on community supervision (Glaze & Bonczar, 2007), the expansion of quality supervision and substance abuse treatment programs would be an effective strategy to reduce the prison population.

It is now time to turn our attention to a broader agenda to ensure that the next decade equips correctional and treatment agencies to use evidence-based practices in daily interactions with offenders that will reduce recidivism. To that end, I will focus on five major themes:

1. Substance abuse treatment works, and is cost-effective. Expanding the use of targeted behavioral therapies, coupled with the use of new medications, to a larger percentage of offenders will reduce recidivism. Currently only about 10 percent of offenders can participate in substance abuse services. This capacity needs to increase to have a substantial system impact.
2. While nearly half of the offenders would benefit from some type of substance abuse treatment service, other offenders need clinical therapies that address criminal thinking and values. A systematic and specific funding stream is not in place to provide other services to reduce criminogenic needs. Together, correctional agencies need to have set mechanisms to fund substance abuse treatment programs and educational, vocational and employment training services for offenders.
3. A national initiative is needed on community corrections—pretrial, probation, and parole—with the emphasis on recidivism reduction strategies. This includes the provision of evidence-based practices and treatments, and building an infrastructure to manage the offender safely in the community.
4. A national network of technology transfer centers focused on disseminating evidence-based practices is needed for judges, correctional agencies, public health, mental health and substance abuse treatment agencies, medical providers, educators, and others that work with the offender population. These centers would augment policy work by focusing on the translation of evidence-based practices into field settings.
5. More research and evaluation is needed to continue the development of knowledge about effective practices and treatments, to understand models for implementing science into practice, and to improve the quality of control and treatment related services to manage the offender in the community.

The emphasis on reentry over the last decade has raised our awareness of the paucity of effective programs and services that exist, while serving to solidify stakeholder commitment to addressing the needs of the offender population. It has also allowed the field to begin to consider how best to provide treatment services for offenders in an era when “rehabilitation” was not allowed to be part of the public dialogue. Good quality drug treatment programs are effective in reducing drug use and criminal behavior, and using such programs is a cost effective crime control strategy. The operations of the prison, probation office, jail, drug court, and diversion programs directly affect the ability of the drug treatment program to deliver the expected results. Drug treatment is an underutilized tool in the effort to control crime; our recent national survey of criminal justice treatment practices illustrates this gap, showing less than 10 percent of the offender population capable of accessing treatment

services on any given day (Taxman, Perdoni, & Harrison, 2007). Without adequate drug treatment services that address addiction disorders and criminal behavior, people will continue to recycle through the justice system, unable to deal with myriad health-related issues that may influence criminal behavior and continue other destructive behavior.

The Need

Offenders are probably one of the unhealthiest subpopulations in our society. According to the National Household Survey on Drug Use and Health (NHSDUH), individuals on probation and parole are four times more likely to have substance abuse disorders than the general population (SAMHSA, 2008). They are also more likely to have mental health disorders (Abram & Teplin, 1991; SAMHSA, 2008). Offenders have more somatic health disorders than the general population (Taxman, Cropsey, Gallagher, under review). These physical health disorders affect success in substance abuse treatment and correctional programs that are designed to reduce criminal behavior. Health disorders include asthma, cardiac disorders, and infectious diseases such as tuberculosis, sexually transmitted infections, HIV, and HEP C. Juvenile offenders are less likely to be immunized than youth overall, and are at higher risk for suicide (Gallagher & Dobbin, 2006). In total, the offender population has a number of unmet medical needs. Constitutional mandates ensure that offenders in prison and jail receive basic medical services while offenders in the community do not have that protection. One study in North Carolina found that offenders returning to the community from prison placed the community at risk for increased sexually transmitted diseases and teenage pregnancies (Thomas & Torrone, 2006); a recent study of youth involved in the juvenile justice system found that they were twice as likely to have sexually transmitted diseases, but unlikely to receive health care due to the high cost of treatment for sexually transmitted diseases at public health clinics. The unmet medical and psychological needs of the adult and juvenile offender populations negatively affect the community, and increase the costs to society. For the most part, less than half of the offenders have completed high school or received a GED (Harlowe, 2003).

In a recent study, we estimated the size of the correctional population that is in need of substance abuse treatment services to be 5.4 million adults and 254,000 youth (Taxman, Cropsey, & Gallagher, under review). The majority of these offenders are in the community, many with prior experiences in prison and/or jail. If we limit our attention to only those reentering the community from prison, we are losing tremendous opportunities to prevent incarceration. The Second Chance Act needs to focus on expanding services for all offenders, with an emphasis on using evidence-based programs.

Facts about Effective Substance Abuse Addiction Treatment Programs

Drug treatment and correctional programs are one of the most effective crime control strategies. This simple fact is based on nearly three decades of research into the effectiveness of drug treatment programs in reducing crime and drug use. A recent article in the *Journal of the American Medical Association* summarizes this large body of knowledge about the efficacy of addiction treatment (Chandler et al., 2009). More specifically, the science around service delivery systems and treatment programs are also known based on clinical trials and the consensus of experts in the field. This is summarized in numerous places, including a booklet by NIDA on *Principles of Drug Abuse Treatment for Criminal Justice Offenders* (NIDA, 2006). Keep in mind that effective treatment services should address the following five principles:

1. Behavioral treatments are effective, and some therapies are more effective than others. For offenders, cognitive behavioral therapies or therapeutic communities are more frequently studied and have been found to be more effective than other interventions, including drug and alcohol education (see Prendergast, Podus, Chang, & Urada, 2002; Taxman & Bouffard, 2003; Wormith et al., 2007).
2. Treatment programs need to be of sufficient duration to affect behavior. Although researchers often assert that treatment should be no less than 90 days, the chronic behavior of offenders argues for longer durations of care (with varying intensity and types of services), ranging from 6 to 9 months (see Fletcher & Chandler, 2006; Taxman, 1999).

3. Treatment programs should be multidimensional, addressing addiction disorders, criminal lifestyle and values, antisocial behaviors, and other factors that influence continued criminality (Wilson, Bouffard, & MacKenzie, 2005).
4. For some addiction disorders (e.g. alcohol, opiates), medications such as methadone, buprenorphine, naltrexone, antabuse, campral and topiramate augment the behavioral therapies. Use of these medications improves the outcomes of offenders considerably, both in terms of reduced drug use as well as reduced criminal behaviors. The medications are important to the recovery process (Cropsey, Villalobos, & St Clair, 2005; Volkow & Li, 2005).
5. Self-help groups should be used to augment behavioral therapies. By themselves, self-help groups are not considered clinical interventions but they provide important support mechanisms.

For drug-addicted individuals involved with the criminal justice system, improving the quality of treatment is just one issue. An often neglected area of discussion is the role of the criminal justice system in improving treatment outcomes. Drug treatment courts, along with other models to integrate treatment into criminal justice processes, have demonstrated that public safety and health goals can be jointly achieved. The drug court concept advanced our understanding of effective components to reinforce the importance of treatment and the need to use criminal justice processes to support recovery and to help offenders learn recovery management skills. To that end, improvements are needed to accommodate effective clinical services by addressing both programmatic and structural issues. The programmatic components identify that:

1. Drug testing is important to monitor the progress in treatment; treatment should be adjusted based on the offender's progress and drug test results;
2. Status hearings (drug courts) or monitoring visits should be focused on clear behavioral objectives, with responses given for swift and certain efforts;
3. Treatment programming should address not only substance abuse but also other criminogenic factors; and,
4. Rewards should be used to shape offender behavior (contingency management).

The structural components to ensure that offenders are placed in programs and services that are focused on their public safety risk and need factors are:

1. Use of standardized risk and need screening tools to identify high risk offenders with priority given for placing such offenders in evidence-based programs and services;
2. Use of treatment engagement strategies that increase the motivation of the offender to engage in treatment. These strategies should be used by criminal justice actors (i.e. judges, probation officers, case managers, etc.) as well as treatment counselors;
3. Emphasis on procedural justice where the rules are clear, recognized, and available to all; procedural justice components have been shown to increase compliance and improve outcomes (Tyler, 2006);
4. Emphasis on recovery management approaches instead of chronic care where treatment is part of a continuum of services designed to address the psycho-social needs of the offender; and,
5. Treatment processes, including medication, should be begin in prison/jail and continue in the community (continuum of care). Recent studies have illustrated that beginning methadone prior to release, increases attendance at community treatment and reduces drug use (Gordon, Kinlock, Schwartz, & O'Grady, 2008; Kinlock et al., 2007; Schwartz, McKenzie & Rich, 2007). Other studies have found that the provision of medications can accelerate recovery, and continued treatment in the community (O'Malley, 2007) and can improve the person's overall health functioning (Pettinati, et al., 2008). The same is true for therapeutic communities and behavioral therapies—therapy should begin in prison but it is critical to continue treatment in the community afterwards to achieve optimal results. The community component is critical to sustained results.

The Gap in Services

Too Few Services Available.

As previously stated, we currently have an insufficient allocation of substance abuse treatment services for offenders, and many of the available services are inconsistent with the multidimensional problems that offenders present. We recently conducted the National Criminal Justice Treatment Practices Survey, funded by the National Institute on Drug Abuse, to understand the landscape of correctional programming and use of evidence-based practices (see Taxman, et al, 2007). As shown in Table 1, the survey reveals that while many correctional agencies offer treatment programs (indicated by ‘% offer’ below), the median percentage of offenders that can access these services is low. This reflects the overall low capacity of the correctional system to provide care for offenders. The programs and services included in the survey were those that were offered either by a correctional agency itself, through a contract, or through an arrangement with another agency (either in-kind, referral based, etc.). One major challenge is the dearth of services available, particularly in the community.

Table 1: Distribution of Services Available

	Prisons		Jails		Community Corrections	
	% Offer	Median % Offenders Access	% Offer	Median % Offenders Access	% Offer	Median % Offenders Access
Physical/Mental Health Services						
HIV testing	89.1	68.7	73.4	22.0	42.0	12.1
HIV/AIDS counseling	80.5	50.1	80.3	27.6	45.2	12.9
Hepatitis C testing	98.2	709.6	74.1	23.3	39.0	11.5
Mental health assessment	99.8	86.5	94.6	39.8	63.6	19.7
Mental health counseling	96.3	58.9	94.5	31.1	63.9	18.6
Pharmacological Therapies						
Methadone	8.9	<1%	54.5	1.7	1.7	<1.0
Medication for Substance Abuse	12.4	N/A	36.8	N/A	2.4	N/A
Medication for Mental Health	80.3	N/A	85.4	N/A	7.8	N/A
SA Treatment						
Detoxification	12.2	<1%	26	1.5	3.2	<1
Alcohol/Drug Education	74.1	8.3	61.3	4.5	53.1	8.8
Outpatient (<4 hours /week)	54.6	3.4	59.8	7.4	47.1	10.0
Intensive Outpatient (5+ hours)	47.1	2.7	22.5	10.8	21.6	8.8
Therapeutic Community (Segregated or non-segregated)	26.9	6.6	26.3	3.0	5.7	11.1

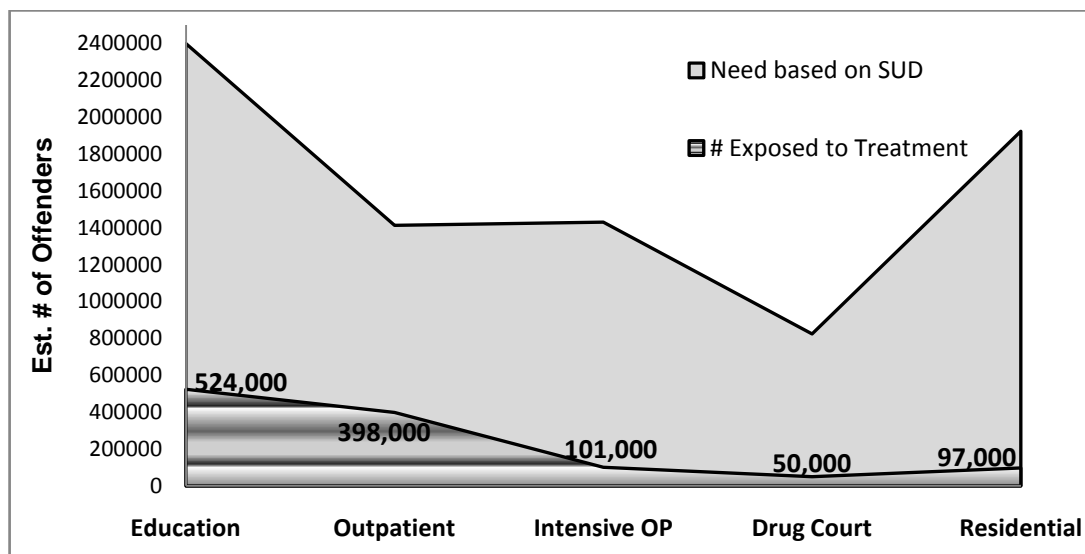
Source: Chandler, Fletcher, & Volkov, 2009; Taxman & Perdoni, 2008

An Imbalance between Offender Need and Services Available.

As discussed briefly above, the offender population is more chronically affected by substance abuse. Based on estimates using the BJS prisoner survey, the estimated need is that 30% do not have a substance abuse disorder, 19% are recreational users, 20% are abusers and 31% have dependent disorders (Belenko & Peugh, 2005). Two points: 1) This distribution would suggest that our services be geared toward treating the complex disorders of offenders; and 2) Many offenders (most likely the recreational user and maybe some of the abusers) would benefit from other types of treatment interventions that address other criminogenic needs. Very few states routinely provide treatment services for other criminogenic needs. As shown above, the majority of services

provided to offenders are more appropriate for individuals with recreational use patterns, such as alcohol education and weekly outpatient counseling programs. Yet, over 51% of the offenders have more serious disorders that by clinical standards would indicate the need for intensive outpatient and residential services, including drug treatment courts. (Note: some adjustments should be made for special populations such as female offenders that require more intensive services (often with mental health services) than males, 18-25 year olds, youth that could benefit from the cadre of family-based therapies, and offenders that are engaged in the entrepreneurship side of the drug business). One critical factor to include is that the public safety risks of an individual should be included in the equation on the nature of services provided to offenders; this would argue for more intensive services for a larger percentage of the offender population. Offenders often have other drivers of criminal behaviors such as criminal value systems, negative peer associations, antisocial personality, and so on that affect the type of treatment services to be offered (see Gornik, 2002 and Taxman, Shepherdson, & Byrne, 2004 for a discussion). Figure 1 compares the need for different modalities of care and the current distribution of services based on annual participation rates (from the National Survey on Criminal Justice Treatment Practices) (see Taxman et al., 2007). We have similar data for juveniles, where the same discrepancy exists between need and available services (see Henderson et al., 2007). Another critical factor in the current service delivery is that offenders in the community are less likely to be able to access services, and when the services are offered, they are inadequate to address their substance use disorder.

Figure 1: Comparison of Substance Abuse Disorder (SUD) Need and Annual Number of Adult Offenders that Can Participate in the Service



Note: The majority of services fall into the alcohol and drug education and outpatient services (group counseling) category. Under a risk management model, offenders with substance abuse disorders would be allocated to higher levels of care. Offenders with use behaviors would be provided interventions for other criminogenic needs or punished appropriately. More emphasis would be placed on providing treatment services geared to the offenders need level.

What is our Current Practice?

One goal of the National Criminal Justice Treatment Services survey was to understand how well the evidence-based practices information has been integrated into the daily operational practice in correctional agencies across the United States. The adoption of scientific information is a major area of study in the field, and an analysis of the patterns of adoption of key practices assists us in better understanding the steps to improve service delivery geared to better offender outcomes (see Taxman, Perdoni, & Harrison, 2007; Young, Dembo, & Henderson, 2007 for an overview of these findings). A few key practices are presented:

- Less than a third of correctional agencies use a standardized risk assessment tool;

- About half of the correctional agencies use some type of standardized substance abuse screening tool with the most frequent tool used being the Addiction Severity Index (ASI);
- Less than 20 percent of agencies report using cognitive behavioral therapies in their clinical programming for offenders, and even fewer use a manualized treatment curriculum (which is recommended to improve the quality of care);
- Around 30 percent of substance abuse treatment programs are 90 days or more in duration;
- The majority of correctional agencies use passive referral strategies to assist offenders in getting access to care upon reentry or while on probation, but the preferred pattern of referrals is active, where appointments are made or treatment and correctional agencies engage in joint placement practices; and,
- Medications for substance abuse disorders are infrequently used for correctional populations.

Current practices do not necessarily equate with evidence-based practices, and a major effort should be developed to assist jurisdictions in moving along this pathway. The above facts illustrate how important it is to provide the necessary assistance to assist correctional and addiction treatment agencies to implement evidence-based practices as a means of advancing correctional outcomes.

In summation, communities and organizations need assistance in improving the quality of care. The most critical step in improving care systems is to convert many of the alcohol and drug education programs and outpatient counseling programs into more intensive services and to assist programs in using the readily-available manualized treatment programs that have been developed by clinicians and researchers and that have been examined for their impact on offender behaviors. The National Registry of Evidence-based Programs and Practices (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA), is one excellent starting point to identify the clinical treatments that have sufficient evidence to warrant implementation. But, more development is needed for interventions for the 18-25 year old population and for interventions that address criminogenic factors such as thinking errors, antisocial values, and other efforts.

A National Initiative on Improving Community Corrections (Pretrial, Probation, & Parole Services)

For the past three decades, reforms have focused on specialized, often boutique programs such as drug treatment courts, RSAT, or reentry. These efforts **did not** address the basic infrastructure for correctional services—pretrial and probation services. Even though the majority of offenders are on probation supervision, there has been no national initiative to reengineer supervision to be a viable practice to manage offenders in the community through evidence based risk management techniques. Reentry efforts thus far have focused more on the services coupled with supervision such as substance abuse treatment, workforce development, family case management, and some mental health services. While the provision of these services is needed, the overall literature informs us that without attention to supervision practices that reinforce the importance of the offender taking responsibility for behavior change, technical violations will increase as well as other failures. *A major lesson from the intermediate sanction movement in the early 1990's was that the failure to pay attention to normal supervision practices actually increased negative offender outcomes.* Supervision agencies have a key role to play in improving offender outcomes, and we should maximize these opportunities (Taxman, 2002; Taxman, 2008; Solomon, et al., 2008).

The recent Pew Report 1:31 outlines the problem—the average daily cost of probation is \$3.52 to \$4.00, parole is \$7.47, and prison is \$78.95 (Pew Report, 2009). The average offender on supervision costs around \$2,200 a year, with outpatient treatment services costing approximately \$1,500. Needless to say, we are not investing sufficiently in assisting offenders to become drug-or crime-free. If you consider that improving substance abuse treatment services (including the use of medications such as Vivitrol or Buprenorphine) might increase the cost of substance abuse treatment services by an additional \$5,000 to \$10,000 a year, this is still half the cost of a year in prison. The underinvestment in community corrections is a challenge before us—it is difficult to alter the course of correctional policy when the infrastructure is not in place to safely and effectively manage the offender population in the community. While the Serious and Violent Offender Initiative (SVORI) and other drug treatment court initiatives over the last two decades have shown that offenders can be more

effectively managed in the community, insufficient capacity in pretrial, probation and parole supervision leaves a void that must be filled. States that are improving their reentry efforts are focused on enhanced supervision as a tool to reduce technical violations and rearrest rates.

For the last 18 years I have had a partnership with the Maryland Department of Public Safety and Correctional Services where we studied an evidence-based supervision model (Proactive Community Supervision). The essence of PCS was to engage the offender in the supervision process, and then to have the offender take ownership for their recovery, access and retention in services (if needed). Supervision staff had a behavioral management role. The same principles derived from systemic evidence based treatments apply: use of risk and need screening tool, target treatment services to offender needs, and manage compliance to improve adherence to a drug- and crime-free lifestyle. Additionally, we recognized early on that attention must be paid to another clinical concept—working alliance—or the development of trust and procedural justice between the offender and supervision staff. Meta-analyses confirm the importance of improving the correctional environment to allow offenders to change as they go through recovery and habituation to assume a citizenship role (Skeem, Eno Louden, Polasheck, & Cap, 2007; Taxman, 2002). Our study found that evidence-based supervision reduced the odds of technical violations by 20 percent and rearrest by 42 percent. These were not low risk offenders, but consisted of offenders that had an average of 6.5 prior arrests (Taxman, 2008).

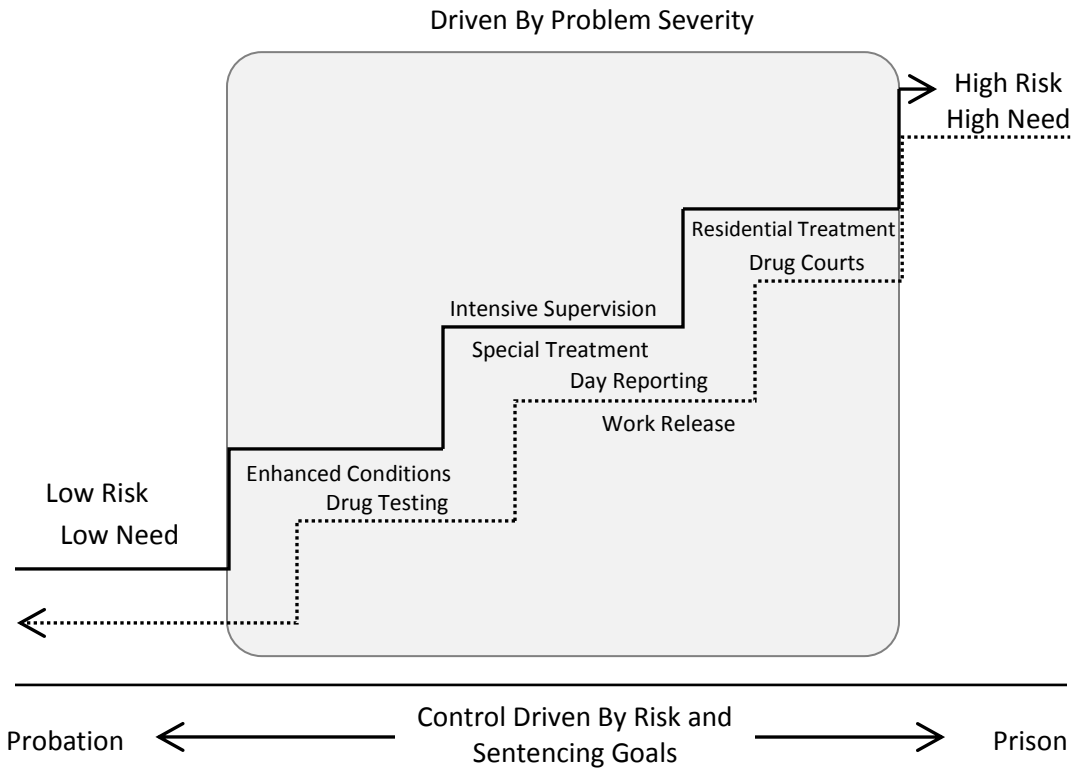
Effective reentry practices—whether it is from prison or jail—and effective supervision practices require attention to the role of the pretrial, probation or parole officer. Current practice is to have the officer be an “enforcer” with an eye toward violation. But science has assisted in identifying roles that maximize motivation to change, and that focus on managing offender behavior. Similar to the drug treatment court, the officer guides the offender through the behavioral change process and adjusts the treatment and control services based on the offender’s performance. Advanced drug treatment courts are also adopting many of these principles of effective behavioral management including the use of risk assessment tools to ensure that the drug treatment court targets high risk offenders. If we have a system of offender management, then we could integrate the use of drug treatment courts and boutique programs into the formula for care such as shown below. Drug treatment courts would be reserved for the high risk offender who is not showing responsibility for his/her own behavior.

The next generation of system reform efforts should focus on the development of a system of offender management, including an expansion in the capacity of community correctional programs. As shown in Figure 2 below, risk and need assessment tools can augment sentencing to determine the level and type of services and controls to safely manage the offender in the community. Effective drug treatment services, other therapies designed to address criminogenic needs, and controls should be targeted to higher risk and need offenders to maximize results. Current reentry efforts, and drug treatment courts, can be used to build this offender management system. An evidence-based approach would include:

- adoption of risk and need assessment instruments;
- development of classification procedures that tie risk-needs to appropriate controls and treatments
- use of evidence-based treatments to address substance abuse disorders including use of manualized treatments; and,
- use of contingency management protocols (rewards) and effective graduated sanction policies to manage offender behavior in the community

Integrated into this model would be a different service delivery system where services and community corrections are intertwined to reinforce the goals of recovery and a crime-free lifestyle. Promising strategies of medications to assist recovery and manage behaviors, clinical therapies for criminogenic behaviors, and stabilization services (i.e. housing, employment, etc.) can be integrated into an offender management model. This formula is being used in various states and /or local jurisdictions that are currently advancing their community supervision practices. A national initiative focused on community corrections should reinforce offender management as a strategy to improve outcomes in the community. The use of recidivism reduction strategies that reduce the use of incarceration could be included in an expanded Second Chance Act that specifies offender management systems based on evidence-based practices and treatments.

Figure 2: Managing Offenders in a System of Care



The focus on enhancing the integration of supervision and services will serve to create a seamless system of care with attention to care management. This is what the Hawaii Hope program has accomplished, as it is integrated with probation for those offenders that are not doing well under supervision, and it provides the compliance management approaches by modifying services (including jail) to meet the performance of the offender. Prior research has demonstrated that fragmented services negatively affect offender outcomes, including the lack of access to and retention in appropriate services (see Taxman & Bouffard, 2000). More efforts within the Second Chance Act should be on integrated services where substance abuse, vocational education, mental health, housing, and other services are integrated into a behavioral contract based on the needs of offenders. And, effective motivation strategies should be used to have the offender develop their own plan to reduce recidivism through a series of targeted services. For example, several research studies have shown that some substance abusers respond to housing vouchers even though they are not mandated (Padgett, Henwood, Stefancie, & Stonhope, 2009). Adjusting services based on need, offender interest, and risk management premised on compliance and outcomes is a behavioral management strategy worth pursuing in a refined justice system.

Technology Transfer Model: Create Correctional Technology Transfer Centers

A major impediment to the advancement of treatment within the criminal justice system, and refined supervision and other criminal justice policies, is the lack of standardized mechanisms to promote the adoption and implementation of science into practice. The Office of Justice Programs (through the Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, and the National Institute on Justice), the National Institute of Corrections (through the Bureau of Prisons), and the Office of National Drug Control Policy do not have systemic processes for improving practice in the field. OJP tends to award a technical assistance contract(s) for specialized programs such as drug courts, RSAT, and reentry, but these contracts vary in scope and

services. In the addiction treatment field, the Center for Substance Abuse Treatment (CSAT) established a network of Addiction Technology Transfer Center (ATTC) in 1993. The ATTC model is to “1) Raise awareness of evidence-based and promising treatment and recovery practices; 2) Build skills to prepare the workforce to deliver state-of-the-art addictions treatment and recovery services, and 3) Change practice by incorporating these new skills into everyday use for the purpose of improving addictions treatment and recovery outcomes” (see <http://www.attcnetwork.org>). The model consists of 14 regional centers and a national office that serves all states and territories. This model has provided a consistent method for translating science to practice, disseminating knowledge and skills, working with the field, and strengthening policy and practice. While the ATTCs work on a limited number of addiction treatments for offenders, they do not address the broader issues of correctional practice or non-addiction treatments. The focus on workforce development is critical because the criminal justice organizations could benefit from a broader range of technology transfer activities geared to the development and implementation of sound policy and practice. The practice improvement collaboratives, which are more predominate in the health care field, are a model worth considering to support correctional agencies, nongovernmental organizations, and other stakeholder groups that are involved in the delivery of services and work directly with offender populations. This model provides a needed infrastructure to work with practitioners and professionals on the diffusion of evidence-based practices, building skills and competence of the field in sound correctional practices, and developing the wide array of professions involved in service delivery such as judges, prosecutors, public defenders, correctional professionals, treatment specialists, workforce development professionals, and so on. To advance practice involves providing the needed infrastructure to disseminate and diffuse evidence-based knowledge into operational settings.

More Research and Development at NIDA and NIJ

As I have discussed, the issues facing our country regarding reentry are issues about techniques to manage the offender population in the community. This requires a mix of policies and procedures along with sound science on effective control and service strategies for offenders with complex problems. The largest funder of quality research is the National Institute on Drug Abuse; the National Institute on Justice or the Office of Justice Programs rarely fund more than a few studies a year, and very few of them are in the area of theoretically driven interventions. The available funding is generally limited to a narrow set of research questions. As we advance policy and pilot new initiatives to improve offender outcomes, research is needed to assess efficacy and effectiveness. For example, the new medications for addiction disorders offer tremendous potential but very few have been studied to examine how best to offer them to offenders with complex issues. We do not know for example whether naltrexone or vivitrol should be offered for three or six months to offender populations or whether some offenders would do better using this medication or another. We also need information on the adaptation of behavioral therapies to address the use of medications (especially for offenders with co-occurring disorders). The available behavioral interventions have not been tested in various settings such as prison, jails or probation offices, and with offenders of varying needs. More research funding is needed to ensure that the next generation of evidence-based practices is based on quality studies on interventions and practices that reduce the risk of recidivism.

References

- Abram, K., & Teplin, L. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist*, 46(10): 1036-1045.
- Belenko, S., & Peugh, J. (2005). Estimating drug treatment needs among state prison inmates. *Drug and Alcohol Dependence*, 77(3), 269-281. doi: 10.1016/j.drugalcdep.2004.08.023.
- Chandler, R.K, Fletcher, B.W, & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *JAMA*, 301(2): 183-190.
- Cowell, A. (2008). Cost Analysis of the Serious and Violent Offender Initiative. American Society of Criminology (ASC) conference, St. Louis Missouri.

- Cropsey, K., Villalobos, G., & St Clair, C. (2005). Pharmacotherapy treatment in substance-dependent correctional populations: A review. *Substance Use & Misuse*, 40(13-14): 1983-1999.
- Fletcher, B., & Chandler, R. (2006). *Principles of drug abuse treatment for criminal justice populations*. Washington, DC: National Institute on Drug Abuse. NIH publication 06-5316.
- Gallagher, C.A., & Dobrin, A. (2006). Deaths in juvenile justice residential facilities. *Journal of Adolescent Health*, 38, 662-668.
- Glaze, L. & Bonczar, T. (2007). *Probation and Parole in the United States, 2006*. Washington DC: Bureau of Justice Statistics. NCJ 220218.
- Gordon MS, Kinlock TW, Schwartz RP, O'Grady KE (2008) A randomized clinical trial of methadone maintenance for prisoners: findings at 6-months post release. *Addiction*, 103(8):1333-42
- Gornik, M. (2002). Moving from correctional program to correctional strategy: using proven practices to change criminal behaviour. *The ICCA Journal on Community Corrections*, April, 24-33.
- Hammett, T. M., Harmon, P., & Rhodes, W. (1999). *The burden of infectious disease among inmates and releasees from correctional facilities*. Prepared for National Commission on Correctional Health Care. Chicago, IL: National Institute of Justice "Health of soon-to-be-released inmates" Project.
- Harlowe, C.W. (2003). *Education and Correctional Populations*. Washington DC: Bureau of Justice Statistics. NCJ 195670
- Henderson, C., Young, D., Jainchill, N., Hawke, J., Farkas, S., & Davis, R. M. (2007). Program use of effective drug abuse treatment for juvenile offenders. *Journal of Substance Abuse Treatment*, 32(3): 279-290.
- James, D.J. & Glaze, L.E. (2006). *Mental health problems of prisons and jail inmates*. U.S. Department of Justice, Bureau of Justice Statistics. (NCJ 213600).
- Kennedy, D. (2009). Personal Communications on Social Networks and Drug Markets.
- Kinlock T.W., Gordon M.S., Schwartz R.P., O'Grady K.E., Fitzgerald T.T., & Wilson MW (2007). A randomized clinical trial of methadone maintenance for prisoners: results at 1-month post-release. *Drug and Alcohol Dependence* 91: 220-227.
- Mumola, C. J., & Karberg, J. C. (2006). *Drug use and dependence, state and federal prisoners, 2004*. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics. Department of Justice publication NCJ 213530.
- National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations: A research based guide*. Rockville, MD: National Institutes of Health.
- O'Malley S.S., Garbutt J.C., Gastfriend D.R., Dong Q, & Kranzler H.R. (2007). Efficacy of extended-release naltrexone in alcohol-dependent patients who are abstinent before treatment. *J Clin Psychopharmacol*. 2007 Oct; 27(5):507-12. PMID: 17873686.
- Padgett, D. Henwood, B., Stefancie, A., & Stanhope, V. (2009). *Substance Abuse Among Dual Diagnoses Homeless Clients Enrolled In Housing First vs Treatment First Programs*. Integrated Services, Integrating Research for Co-Occurring Conditions: A need for New Views and Action, Bethesda, MD.
- Pettinati H.M, Gastfriend D.R, Dong Q, Kranzler H.R, & O'Malley S.S. (2008). Effect of extended-release naltrexone (XR-NTX) on quality of life in alcohol-dependent patients. *Alcohol Clin Exp Res*. 2009 Feb;33(2):350-6. PMID: 19053979
- Prendergast, M., Podus, D., Chang, E., & Urada, D. (2002). The effectiveness of drug abuse treatment: a meta-analysis of comparison group studies. *Drug and Alcohol Dependence*, 67(1): 53-72.
- Sampson, R. J., & Laub, J. H. (2005). A Life-Course View of the Development of Crime. *The ANNALS of the American Academy of Political and Social Science*, 602(1), 12-45.
- Schwartz, R.P., McKenzie M, & Rich J.D.. Opioid Addiction and Incarceration: An overview. *Medicine and Health/Rhode Island*. 90(5) 157-158.
- Skeem, J., Eno Louden, J., Polasheck, & Cap, J. (2007). Relationship quality in mandated treatment: Blending care with control. *Psychological Assessment*, 19, 397-410.
- Solomon, A. L. Jannett, J., Elderbroom, B., Winterfield, L, Osborne, J., Burke, P., Stroker, R.P., Rhine, E.E., Burrell, W. D., (2008). *Putting Public Safety First: 13 Strategies for Successful Supervision and Reentry*. Washington DC: Urban Institute. <http://www.urban.org/url.cfm?ID=411791>

- Substance Abuse and Mental Health Services Administration (SAMHSA). (December 31, 2008). SAMHSA's latest National Survey on Drug Use and Health. Retrieved March 6, 2009 from the U.S. Department of Health and Human Services website: www.oas.samhsa.gov/nsduh/2k7nsduh/2k7Results.pdf
- Taxman, F. S., & Bouffard, J. (2000). The importance of systems in improving offender outcomes: New frontiers in treatment integrity. *Justice Policy Journal*, 2: 37-58.
- Taxman, F., Cropsey, K., & Gallagher, C. (under review). The Unmet Medical Needs of Correctional Populations
- Taxman, F., Henderson, C., & Belenko, S. (in press). Integration of Drug Treatment in Correctional Agencies: Organizational Factors. *Drug and Alcohol Dependence*.
- Taxman, F.S., Perdoni, M., & Harrison, L. (2007). "Treatment for Adult Offenders: A Review of the State of the State," *Journal of Substance Abuse Treatment*, 32(3), 239-254.
- Taxman, F. S., Shepardson, E., & Byrne, J. M. (2004). *Tools of the trade: A guide to incorporating science into practice*. Washington, DC: National Institute of Corrections. <http://www.nicic.org/Library/020095>
- Taxman, F.S., Young, D. & Byrne, J. (2004). Transforming Offender Reentry into Public Safety: Lessons from OJP's Reentry Partnership Initiative, *Justice Policy and Research*, 5(2),101-128.
- Taxman, F.S. & Bouffard, J. (2003). Substance Abuse Counselors' Treatment Philosophy and the Content of Treatment Services Provided to Offenders in Drug Court Programs, *Journal of Substance Abuse Treatment*, 25,75-84.
- Taxman, F.S. & Bouffard, J. (2003). Drug Treatment in the Community: A Case Study of Study Integration, *Federal Probation*, September, 1-23.
- Taxman, F.S.(2002). Supervision – Exploring the Dimensions of Effectiveness, *Federal Probation* 66(2), 14-27.
- Taxman, F.S. & Bouffard, J. (2000). The Importance of Systems in Improving Offender Outcomes: New Frontiers in Treatment Integrity, *Justice Policy Journal* 2(2), 37-58.
- Taxman, F.S. (1999). Unraveling "What Works" for Offenders in Substance Abuse Treatment Services, *National Drug Court Institute Review* II(2), 93-134.
- Teplin, L.A., Abram, K.M., McClelland, G.M., Mericle, A.A., Dulcan, M.K., & Washburn, J.J. (2006). *Psychiatric Disorders of Youth in Detention*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (NCJ-213600).
- Thomas, J. C., & Torrone, E. (2006). Incarceration as forced migration: Effects on selected community health concerns. *American Journal of Public Health*, 96, 1762-1065.
- Tyler , T.R. (2006). Legitimacy and legitimation. *Annual Review of Psychology*, 57, 375-400.
- Volkow, N., & Li, T. K. (2005). Drugs and alcohol: Treating and preventing abuse, addiction, and their medical consequences. *Pharmacological Therapy*, 108(1): 3-17
- Wilson, D., Bouffard, L., & MacKenzie, D. (2006). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. *Criminal Justice and Behavior*, 32(2): 172-204.
- Wormith, J., Althouse, R., Simpson, M., Reitzel, L., Fagan, T., & Morgan, R. (2007). The rehabilitation and reintegration of offenders—the current landscape and some future directions for correctional psychology. *Criminal Justice and Behavior*, 34(7): 879-892.
- Young, D.W., Dembo, R., Henderson, C.E. (2007). A national survey of substance abuse treatment for juvenile offenders. *Journal of Substance Abuse Treatment*, 32, 255-266.