I. MOVING FROM POLICY TO ACTION

A. INTRODUCTION

Substance abuse leads hundreds of thousands of people into the criminal and juvenile justice systems each year, many in need of treatment. There have been numerous creative responses to the challenges presented by the growing number of offenders with substance use disorders -- TASC programs, boot camps, and drug courts to name a few. Unfortunately, the tendency of the justice systems to focus on individual programs, no matter how good, results in episodic treatment of small percentages of the population in need. TASC programs and drug courts are operating effectively, but in only a small fraction of the counties in the United States. Systemic policies, not merely programs, must become the focus for efforts to link treatment with the justice systems. Substance use disorders and related crime put both public safety and public health at risk, and require a response that combines both justice and public health expertise and interventions.

In March of 1998, scholars, policy makers, and practitioners from around the country met with ONDCP and the Departments of Justice (DOJ) and Health and Human Services (HHS), to focus on systemic policy. This consensus meeting assessed existing knowledge regarding drug treatment and the justice system, probing scientific research and clinical experience to determine what is known with reasonable confidence. The participants found that a great deal is known, but also found that what is being done is often not consistent with what is known.

To help bridge the gap between research and application, ONDCP crafted a draft policy statement reflecting the state of established knowledge and circulated it, first among Federal agencies and then among major stakeholder organizations. On June 25, 1999, forty stakeholder organizations met in Washington to advise DOJ, HHS, and ONDCP on the essential content of national policy addressing drug treatment and the justice systems. These, and other, organizations provided a number of helpful suggestions for revision.

The revised paper was presented for consideration at the ONDCP/DOJ/HHS-sponsored National Assembly on Drugs, Alcohol Abuse, and the Criminal Offender, in December 1999. The Assembly was an unprecedented gathering of over 800 public health, social service, and justice officials from all branches and levels of government. Participants included representatives from: all of the states, 15 local jurisdictions, 50 national organizations, foundations, mental health, public health, juvenile justice, substance abuse treatment, elected officials, law enforcement, prosecution, judges, probation, parole,

pretrial, and defense. This paper incorporates refinements based on discussion at the Assembly.

NOTE: New or technical terms are generally defined at the point where they are used in this paper. One term, in particular, warrants specific mention. The term "substance use disorder" is used throughout the paper in its clinical sense. It is a broad term that encompasses abuse and dependence, which are both diagnostic categories used by clinical experts.

B. POLICY STATEMENT

Working in concert, justice and public health agencies can establish a continuum of accountability and treatment for juvenile and adult offenders with substance use disorders. The following statement addresses the content of policy to establish such a continuum.

The criminal and juvenile justice systems should operate – in concert with other service systems - as a series of opportunities for intervention with offenders experiencing substance use disorders. Interventions should be carried out in a systematic manner and at the earliest possible opportunity:

- *To prevent entry into the criminal/juvenile justice system for those who can be safely diverted to community social service systems.*

- *To limit penetration into the criminal/juvenile justice system for nonviolent offenders through community justice interventions in concert with other social service systems.*

- *To intervene with those who must be incarcerated or securely confined, through appropriate treatment and supervision, both during and after the period of confinement.*

C. GETTING STARTED: A NINE-POINT ACTION CHECKLIST

***Improving public safety and public health requires systematic interventions to bring about long-term change in the substance abusing and criminal behaviors of offenders*.** Treatment must be a priority of the justice system and incorporated into the routine practices and decisions of justice officials. More than simple coordination is required for the justice system to work effectively with public health service providers, largely because the primary focus of the former is public safety, while the latter focuses primarily on improving the lives of individual clients. Policies and operational procedures must cross organizational boundaries to make treatment decisions a critical element of justice decisions. The following checklist is offered as a quick reference for those communities that intend to move beyond coordination of programs to full collaboration among community agencies with integrated decisions and services.

1. SET THE STAGE. Recognize substance abuse as a public health and public safety problem that requires the collective efforts of the health and justice communities working in an integrated fashion. The two systems must adopt a policy requiring public health services to be intertwined with justice services to change the behavior of adult and juvenile offenders**.**

2. FIRST THINGS FIRST. Identify areas where collaboration will result in long-term benefits. It is common practice for treatment agencies to make decisions based on clinical criteria, while justice agencies make decisions based on security criteria. Many of these decisions have consequences for both systems as well as for the community and the offender. Yet decisions are seldom made jointly and decision information is often not shared in a timely manner. Operational procedures can and should be developed to ensure joint decision making in areas that impact both the health and justice systems: assessment, treatment placement, treatment monitoring protocols, drug testing protocols, and treatment discharge. Joint decision making in these areas would foster long-term behavior change for adult and juvenile offenders and reduce threats to public safety and health.

3. **TREATMENT'S CONTRIBUTION. Recognize treatment as a key element in crime control**. Treatment is not an ancillary service. Rather, treatment is important to the reduction of recidivism and substance seeking and abusing behaviors. Such recognition by public health, justice, and the general public will focus attention on expected outcomes (e.g., law-abiding citizens who are managing their substance use disorder). It will also encourage public health officials to acknowledge that treating the offender is a major community priority and to make required changes in the existing delivery system.

4. THE IMPORTANCE OF ASSESSMENT. Employ assessment protocols that address both substance use and juvenile/criminal justice factors. Too often the justice and public health systems do separate assessments. Few states have mechanisms that allow the public health system to access justice records, requiring them to rely on offender self-report, and health information is often not available to the justice system. Thus, treatment and justice decisions are often made without having complete justice and clinical assessments. To guide treatment and justice decisions, States should develop an assessment of risk to public safety, as well as substance use severity, that incorporates mental health, primary health, and social services needs. In addition, States should explore ways to encourage the sharing of information among service systems.

5. RATIONAL PLACEMENT. Adhere strictly to placement based on an assessment of safety risk and the severity of substance use disorders. Often offenders are placed in the program with the first available slot instead of matching the service needs of the offender with the service provision of a program. Treatment placement protocols are needed to place offenders in appropriate treatment programs, offering the treatment and justice monitoring suited to the risk level of the offender.

6. INDIVIDUAL TREATMENT PLANS. Employ the assessment to develop an individual treatment plan for each offender. Many offenders will present mental and primary health problems and life skills deficits, in addition to substance use disorders and criminal thinking disorders. The individual treatment plan should serve as the blueprint for coordinating services and supervision, as well as a basis for assessing offender progress and program performance.

7. RIGOROUS CASE MANAGEMENT. Manage offenders in treatment with testing, supervision, sanctions, and incentives. Adult and juvenile offenders in treatment must be closely supervised and their cases tightly managed. Supervision and treatment components must function as a team for case management where decisions regarding level of care, testing, supervision, and sanctions/incentives are made together. The power of treatment and justice working together is the consistent message to the offender, i.e., substance abusing and criminal behavior are unacceptable and the offender must change his/her behavior. Drug testing is an important offender management tool and should be used throughout the treatment process. Both treatment and justice agencies should have timely access to drug testing information as a routine operational procedure tied to sanctions and incentives, which in turn must be swift and certain, to reinforce the message of accountability.

8. STRUCTURED ACCOUNTABILITY. Be fair and predictable in delivering sanctions and incentives. Offenders respond to situations that they believe are fair and just, and to sanctions and incentives that are uniformly applied. To be effective, sanctions must be administered by treatment and justice staff in adherence to an adopted sanction protocol, delivered shortly after the infraction and with predictable certainty, and graduated

to fit the infraction. Incentives should be provided in a similar manner, to complement sanctions, and tied to behavioral objectives achieved by the offender.

9. FOLLOW THROUGH. Extend the impact of treatment by providing a continuum of supervision and support. Many offenders have a significant history of substance abuse and criminal activity and require treatment programs of significant duration. Such programs can be accomplished in a cost-effective manner, by providing different levels of treatment intensity as required. It is critical that adult and juvenile offenders receiving treatment in correctional or other secure facilities continue with treatment and supervision in the community. Rigorous transitional and follow up services will maximize the recidivism reduction potential of treatment.

II. IMPLEMENTING INTERVENTIONS - A DETAILED CHECKLIST

The following set of recommended actions is organized and presented in checklist form to reflect the stages of criminal and juvenile justice involvement, starting with arrest, as opportunities for intervention. ONDCP's "Breaking the Cycle" initiative is now pursuing these actions with adult offenders in three sites and with juveniles in one. SAMHSA/CSAT's criminal and juvenile justice treatment networks are using a similar approach in four adult and three juvenile sites. A collaborative approach, spanning both the division and separation of powers, will be essential to a national effort; however, small steps taken now can have an immediate effect.

NOTE: References to the threat of incarceration as a means to foster treatment compliance are not intended to suggest that an offender who would not otherwise warrant incarceration would be subject to incarceration for failure to comply with a treatment program. Furthermore, the critical information sharing that is called for throughout the system is subject to existing Federal law and regulations addressing confidentiality.

A. Community-based Interventions

1. Diversion/Pretrial Release

- ❑ At the time of arrest, all adult and juvenile arrestees should be screened for drug and alcohol problems and the risk they present to the safety of the community. Public defenders should be allowed the opportunity to participate in diversion deliberations.

- ❑ All who test positive, and are eligible for diversion or pretrial release, should have their release conditioned on compliance with a regimen of drug testing.

- ❑ All who test positive during the period of release should face graduated sanctions.

- ❑ All who test positive should be assessed to determine the need for and appropriate level of drug treatment.

- ❑ Those assessed to be in need of drug treatment, and who are eligible for diversion or pretrial release, should be referred to appropriate treatment and have their release conditioned on compliance with the treatment plan.

- ❑ The target caseload for pretrial officers supervising offenders with substance use disorders should not exceed 25, to allow for intensive supervision and frequent testing.

- All who fail to comply with treatment during the period of release should face graduated sanctions, culminating in pretrial detention for releasees unable or unwilling to comply. When appropriate, incentives should also be employed to encourage compliance with and retention in treatment.

- Eligible offenders who comply with the conditions of release should be given the opportunity to continue on release contingent on continued compliance.

- Eligible adult and juvenile offenders who continue to comply with conditions, including those who successfully complete treatment, should have the charges against them dismissed or adjourned in contemplation of dismissal (i.e., compliant first offenders will have no criminal record, other compliant offenders no additional record of conviction or adjudication).

- Information gathered during the pretrial/pre-adjudication process should be made available for those defendants/offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

2. Pretrial Detention

- Those detained and assessed to be in need of drug treatment should be placed in an appropriate treatment program and compliance with the treatment plan should be part of the case disposition for those convicted/adjudicated.

- Information gathered during the pretrial process should be made available for those defendants/offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

3. Sentencing

- For all adults and juveniles that are tried/adjudicated and found guilty/responsible, a pre-sentence investigation/report should be completed.

- The sentencing/disposition judge should incorporate information from pretrial activity (treatment need, type of treatment initiated, compliance with testing and treatment conditions, compliance with other conditions) into the sentencing process, and include continued compliance with testing and treatment requirements as a part of the sentence. Post-release supervision should be part of any sentence to incarceration for adult and juvenile offenders with substance use disorders.

- Information gathered during the trial and sentencing process should be made available for those offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

4. Community Corrections

- Those sentenced to probation, with a condition of compliance with drug treatment during probation, should be placed in an appropriate treatment program (those in pretrial release should continue in the program started during pretrial; others should continue in a program consistent with the one started during pretrial) and compliance with testing and treatment program conditions should be a primary consideration in the decision to end probation.

- The target caseload for probation, parole, and other community corrections officers supervising offenders with substance use disorders should not exceed 25, to allow for intensive supervision and frequent testing.

- Contacts with the probation or other community corrections officer should be frequent and offenders who fail to comply with treatment conditions should face graduated sanctions, culminating in appropriate detention for those unable to comply (e.g., short- or long-term incarceration, residential treatment, institutional training school placement). When appropriate, incentives should also be employed to encourage compliance with and retention in treatment.

- Information gathered during the community corrections period should be maintained to follow those offenders that remain in or are returned to the criminal and juvenile justice systems.

B. Institutional Interventions

1. Jail/Detention

- Jails/Detention facilities should establish necessary procedures to maintain a drug-free environment, including testing for inmates and detection procedures for others. Inmates who test positive should face graduated sanctions, culminating in an extended period of detention as a result of loss of good time credit.

- Those sentenced, with a condition of compliance with drug treatment during and after incarceration, should be placed in an appropriate treatment program (when practicable, those in pretrial detention will continue in the program started during pretrial/pre-adjudication; others will continue in a program consistent with the one started during

pretrial) and compliance with treatment program conditions should be a primary consideration in release decisions and in post incarceration conditions.

- Information gathered during the jail/detention period should be made available for those offenders that remain in or are brought back into the criminal or juvenile justice systems (i.e., made available to inform each subsequent decision).

2. Prison/Juvenile Corrections

- Prisons/juvenile corrections should establish necessary procedures to maintain a drug-free environment, including testing for inmates and detection procedures for others. Inmates that test positive should face graduated sanctions, including the loss of good time credit, which can result in an extended period of incarceration.

- Those sentenced to incarceration, with a condition of compliance with drug treatment during and after incarceration, should be placed in a treatment program consistent with programs provided earlier, unless further assessment indicates the need for an adjustment. Compliance with treatment program conditions should be a primary consideration in release decisions and in post incarceration conditions.

- Eligible adult and juvenile offenders that successfully complete a program of treatment and rehabilitation within the institution should be considered for early release to transitional and community follow up treatment.

- Planning for transition of adult and juvenile offenders back to the community should be accomplished well in advance of release and should include: clear conditions for release with clear sanctions for noncompliance; assurance of continuing, compatible treatment in the community; access to needed vocational, social, and housing services, and an established regimen of testing and supervision.

- Information gathered during the incarceration period should follow offenders through the remaining justice processes (i.e. made available to inform each subsequent decision).

C. Community Interventions and Offender Re-entry

1. Post Incarceration

- For adult and juvenile offenders subject to post-release supervision, compliance with treatment and testing conditions should continue for a minimum of six months after return to the community. Those who test positive or otherwise fail to comply with testing and treatment conditions should face graduated sanctions, culminating in re-

incarceration for those unable to comply with the conditions of release. When appropriate, incentives should also be employed to encourage compliance with and retention in treatment.

- Information gathered during post-incarceration supervision should be maintained to follow offenders through any subsequent decisions.

III. BACKGROUND AND DISCUSSION

A. THE NEED TO RECONSIDER EXISTING POLICY

Existing policy relies heavily on incarceration, notably so for drug offenders. Today, incarceration is a common result of conviction, sentences are longer, and probation and parole revocations are on the rise. Prisons and jails hold nearly 1.9 million persons.[1] Between 1986 and 1998 , time actually served under Federal sentences nearly doubled - from 14.5 months to 28 months. The increase is mostly explained by sentences served for drug offenses, weapons offenses, and immigration offenses. For Federal drug offenders, time served more than doubled – from 20.4 months to 42.5 months, while increases for violent and for property crime were ten and one percent, respectively.[2] At the state level parole violators constituted 37 percent of 1998 prison admissions, compared to 18 percent in 1980.[3] As a result in 1999 , despite significant prison construction, State prisons were operating at between 1 and 17 percent above capacity, while Federal prisons were operating at 32 percent above capacity.[4] Crowded facilities have less room for needed programs[5].

Incarceration is an important but limited element in the maintenance of public safety. By itself, incarceration can incapacitate violent offenders for a period of time (e.g., an average of 53.7 months in the Federal system in 1998).[6] However, incarceration alone is a limited and costly response that causes harm when improperly employed, and is not an effective alternative to treatment for offenders with mental health and substance use disorders.

Community health and safety require a periodic assessment of the policies that determine which offenders are to remain in the community, which are to be incarcerated, and which interventions are to be employed in each setting.

Incarceration is a costly approach. In 1996, states and localities spent over $27 billion in corrections, over $21 billion for prison operations alone. The average annual cost per inmate was $20,142, ranging from a low of $8,000 to a high of $37,800. For the Federal system annual cost per inmate was $23,500.[7] By comparison, probation and parole costs, in 1997, ranged from $1,110 per year for regular supervision, to $3,470 for intensive supervision, and to $3,630 for electronic supervision. Cost variation is explained primarily by caseload. The average caseload for regular probation was 175, for regular parole 69. The average caseloads for intensive supervision probation and parole were 34 and 29, respectively; for electronic supervision 20 and 18.[8]

There are also indirect costs of incarceration. For example, it drains resources from other criminal justice activities and ultimately from other social services. Further, there are social costs including tax and welfare revenue and costs to families and communities of

having a relative and resident removed. Therefore, cost-conscious public safety may require a policy with less emphasis placed on retribution and more on incapacitation when deciding whom to imprison.

By comparison, treatment is inexpensive. Using the Federal Bureau of Prisons as a representative institutional program, the cost of residential and transitional treatment and services is estimated at $3,000 per inmate. Generally accepted estimates of annual treatment costs per person in the community are: regular outpatient, $1,800; intensive outpatient, $2,500; short term residential, $4,400; and long term residential, $6,800. Thus, combining the most expensive community supervision with the most expensive treatment yields an estimated average cost of $10,430 per person per year compared to $20,142 for incarceration alone, and $23,142 for incarceration combined with treatment and transitional services.[9]

Incarceration alone will not make communities safe. The contribution of incarceration alone to public safety is limited. Prisons/detention centers are a temporary response that addresses a third of the offenders under criminal justice supervision; the remaining 4.4 million offenders are in community programs. Over a million offenders under criminal justice supervision need, and are not getting, drug treatment. And each year over 550,000 people return to their communities from state and Federal Prisons; most untreated and many, therefore, dangerous, unemployable, sick. Over 350,000 (two-thirds) will be rearrested within three years of release. With treatment during and after incarceration this level of recidivism can be sharply reduced.[10]

Furthermore, while it is likely that policy favoring incarceration has made some contribution to the decrease in violent crime over the last six years, it is also likely that the exploding prison population now includes offenders who could be managed and treated safely and effectively in the community; perhaps eight percent or more "drug only offenders," according to the Manhattan Institute.[11] Studies by Federal agencies and private organizations, including the RAND Corporation, the Manhattan Institute, and the National Center on Addiction and Substance Abuse at Columbia University (CASA), suggest that we need to do a better job of deciding whom to put behind bars and what to do with them while they are there.

Incarceration alone will not change the behavior of offenders with substance use disorders. Offenders with substance use disorders are responsible for a disproportionate amount of crime. During periods of heavy or addicted use, the frequency and severity of criminal activity rises dramatically. A survey of chronic drug users not in treatment in 1992 found that over half were involved in illegal activity, with 10 percent deriving income solely from illegal sources. Fortunately, entry into drug treatment has been shown

to have an immediate impact on the levels of drug use and associated crime, and retention in drug treatment to have a significant impact. About 6.3 million people are on probation, in jail or prison, or on parole. Reliable, consistent data on treatment needs among criminal justice populations are sparse, as are data on the quality of programs being offered. However, a very conservative estimate would be that over a million offenders under criminal justice supervision need, and are not getting, drug treatment.[12] Returning these offenders to their communities, without treatment intervention, is a significant missed opportunity and a threat to public safety.

Treatment can change the behavior of offenders, including incarcerated populations. Major longitudinal studies have repeatedly shown that drug use and criminal activity decline upon entry into treatment and remain below pre-treatment levels for up to six years. The 1998 interim report of the evaluation of the Federal Bureau of Prisons' (BOP) Drug Treatment Program (a collaborative effort of NIDA and BOP) found that six months after release, the population receiving treatment was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than the control group. The 1999 report of the NIDA-funded Evaluation of the Delaware Prisons Drug Treatment Program found that, three years after release from custody, the population that participated in both institutional and transitional treatment programs was 69 percent arrest free and 35 percent drug free, compared to 29 percent and five percent, respectively, for the non-treatment group.

State evaluations have yielded similar results. Colorado followed up on treatment graduates and found that, among those who had been arrested in the two years prior to treatment, 80 percent had no arrests. Maine followed treatment graduates for a year and found that 78 percent had no arrests. Washington found that, after four years, substance abusing traffic offenders diverted from prosecution to treatment had a 22 percent recidivism rate compared to 48 percent for those who had been convicted. And Texas found, after a one-year follow up of treatment graduates, that 80 percent had no arrests.[13] The interrelationship of public safety and public health is evident at each stage of the justice system.

***Community service resources have been allowed to erode*.** The Drug Abuse Treatment Outcome Study (DATOS) found fewer social services available for those in treatment than had been the case in earlier national studies.[14] Excesses in managed care have restricted access to the services available and shifted costs to the public sector. The inability of eroded community services to intervene effectively brings many to the criminal or juvenile justice system for their treatment. This is especially so in rural areas where, for example, Native Americans have an arrest rate for alcohol violations more than double the national rate. On any given day, our jails house more than 25,000 people suffering from both mental illness and substance use disorders. Over 300,000 are affected by one or the other disability. Over half of the inmates in state and Federal prisons have a mental health or

substance use disorder – nearly 700,000. Over 200,000 suffer from the most serious mental illnesses.[15]

Community justice resources have deteriorated. Community corrections has experienced an erosion of infrastructure similar to that of other community services. From 1980 to 1999 , the percentage increase (400 percent) of offenders in prison has been greater than the increase for any other type of correctional supervision . When jails are included the overall percentage increase in incarcerated offenders is 375 percent.[16]During this same period, the number of probationers and parolees increased by 337 percent and 323 percent, respectively, yet sufficient resources have not been allocated to keep caseloads manageable.

In a majority of cases, offenders mandated to treatment are assigned to parole, probation, or some other form of community supervision. Community supervision includes a range of governmental activities designed to punish, manage, control, and rehabilitate offenders in the communities where they live. Parole and probation officers often work with private agency service providers to supervise offenders in community settings and change negative behaviors and habits. Community supervision allows offenders to maintain work and family ties and to compensate victims and communities for costs associated with their crimes. For such programs to be effective, they must be well coordinated, adequately staffed, and supported with a strong intergovernmental infrastructure. Supervision is impossible with caseloads in the hundreds and very difficult with caseloads over 25. Given probation caseloads that average 175 and range to 900, surveillance has replaced supervision in many communities.[17]

***Local political leadership is not consistently called upon*.** Agency decision-makers at different levels of government and in different branches sometimes fail to take the views of local political leadership into account and thus deny themselves the systems overview of elected officials, which is necessary for effective collaboration.

State and local discretion is undermined. Existing policies are sometimes fragmented and contradictory, and rely heavily on incarceration as a means of retribution, rather than community justice as a means of rehabilitation, deterrence, and incapacitation. Mandatory minimums constrain local discretion, often replacing cooperative state and local relationships with pressures toward incarceration. For example, a local decision to imprison an offender may shift the cost from the county to the state. Similarly, in some jurisdictions, a probation or parole officer's decision to revoke shifts the caseload from community corrections to the state. Many legislatures prohibit numerous possessions and activities for inmates, thus depriving correctional administrators of powerful motivational tools. Prison and jail administrators should be allowed the flexibility to employ a broad range of sanctions and incentives to discipline infractions, motivate change, recognize progress, and enhance staff safety.

Actions are too often assessed in terms of intended rather than actual consequences. Some current policies have unforeseen, long-term, negative consequences. For example, decisions to prosecute and convict -- rather than divert -- nonviolent youthful offenders leave many young people with a criminal record that will present a lifelong obstacle to employment and full civic participation. For the juvenile justice system decisions to adjudicate and commit -- rather than divert -- nonviolent offenders have similar consequences.

Mental health, primary health, race and ethnicity, age, and gender are often not adequately addressed by existing interventions. Many juvenile and adult offenders with substance use disorders also have co-occurring mental disorders and primary health care needs. For example, approximately 13% of the prison population have both a serious mental illness and a co-occurring substance abuse disorder[18], and many others have or are at risk for HIV/AIDS and other infectious diseases. Fully one-third of the people in the U.S. with TB pass through correctional facilities. For Hepatitis C, HIV, and AIDS the numbers are one-third, 18 percent, and 17 percent.[19] To be maximally effective, treatment must address these co-occurring health conditions, must be appropriate to the age and gender of the offender, and must be appropriate to the offender's race and ethnic heritage. Treatment should also involve the offender's family, when possible. The children of substance abusing offenders are at higher risk for substance abuse and criminal behavior themselves. Therefore, treatment that involves the offender's family can help to break the intergenerational cycle of substance abuse and crime.

The juvenile justice system is not fully recognized as a cost-effective opportunity to prevent the cycle of substance abuse and crime. The juvenile justice system was specifically developed to respond to young offenders differently than the adult justice system. Since its inception, the primary goal of juvenile justice has been rehabilitation rather than punishment, focusing on youth in the context of the family. However, despite research in recent years that supports the wisdom of maintaining a separate juvenile justice system, a departure from this approach has begun. Forty-six states have adopted laws permitting some juveniles to be tried and sentenced as adults.

The relationship between youth drug use and crime has been established but is complicated by the fact that youth are risk takers and experimenters by nature, and will sometimes engage in behaviors that are illegal. From a developmental perspective, adolescence is a major transitional phase that is defined by significant physical development coupled with increases in aggressive behavior, increased conflicts with parents and other authority figures, and an orientation away from family and toward peers and experimentation. Recent brain research strongly suggests that youth simply do not have the same capabilities as adults for impulse control, prioritization, and planning. They are still developing members of families and the community. Experimentation of all sorts is

common, including the use of illicit substances, and does not necessarily portend later problems since many adolescents progress through this period and into adulthood without additional significant troubles. Most substances are illegal for youth and use is subject to legal and judicial response. Thus, adolescent risk-taking and experimentation pose serious questions for the juvenile justice system, including how to avoid the wide-spread criminalization of unacceptable but transitory behavior. One key challenge is to develop interventions that address unacceptable behavior before a youth becomes involved in the juvenile justice system.

For youth that do enter the juvenile justice system, opportunities to provide comprehensive treatment and services for substance abusers and their families should be recognized. There are several points of potential intervention with youth. In a comprehensive system, the first point of intervention is prior to any involvement with the juvenile justice system. This requires the identification of high-risk youth by community institutions and the provision of services that prevent or minimize involvement with the justice system. Other points of potential intervention are arrest or intake, fact finding hearings, community-based diversion, adjudication, probation, and detention.

Treatment and supervisory responses to youth must be different from those for adults. Youth are much more likely to be substance users and abusers, but not, or not yet, dependent. Thus, a different clinical approach is required. Youth often do not respond well to supervisory techniques that work with adults. The institutional and legal settings for youth and adults are substantially different. And there are youth-specific issues concerning consent, due process, and confidentiality. For youth, the family, community, and schools play a prominent role and must be incorporated into any comprehensive solution. Thus, a collaborative approach, linking youth-related service systems, appears to offer the best opportunity to engage youth and their families in treatment, appropriate supervision, and sustained rehabilitation.

Research on adolescent treatment and supervision is not as extensive as for adults. A major effort will be required to demonstrate interventions that are successful in preventing high-risk youth from becoming involved in the juvenile justice system. Fortunately, there are some promising approaches. One is “strength-based,” identifying and building on the positive attributes of youth, their families, and communities, rather than focusing exclusively on what the youth has done wrong. Another approach assesses the youth’s behavior in the context of the family system and the community, and fashions interventions that address the family as well as the individual.

Finally, there are compounding factors that cannot be ignored. For one, there is concern that some minority groups are entering the juvenile justice system at a rate disproportionate to their criminal activity. And there are some disturbing statistics that require review. For example, African-American youth, 15 percent of the 10 to 17 year-old

population, account for one-third of those referred to, processed by, and convicted in juvenile court[20] and half of those transferred from juvenile to adult court.[21]

B. A BRIEF OVERVIEW OF EXISTING KNOWLEDGE

Our knowledge regarding addiction, treatment, and justice interventions has grown substantially over the past decade. A large and growing body of research is consistently clear on a number of points that are key to public policy. A recent NIDA publication outlines the principles that can be drawn from the research.[22]

Recent research has taught us that, although addiction is a complicated state, it invariably involves changed brain chemistry. The brain chemistry of the addict has become different from that of the person who does not use drugs. Indeed, the addict's brain is different from that of most people who have used drugs, although all users run the risk of altered brain chemistry over time. With heavy, frequent drug use the change can be profound.

Furthermore, drug seeking and using behavior trains the brain. Addicts are not simply sick people. Rather they are sick people who engage in a web of behaviors that exacts a toll on the health and safety of all society's institutions, starting with the family. Addicts cannot, and some abusers do not want to, control their behavior. Many resist efforts to bring their actions in line with the requirements of society. Some suffer from co-occurring mental disorders that further complicate rehabilitation.

Structured interventions can get chronic abusers of drugs and alcohol into treatment, retain them, provide the supervision and support required to start them on recovery, and enable them to maintain their recovery over the long term. Long-term progress in reducing and managing this population requires a rehabilitation approach that: confronts and exposes thinking errors and the addictive lifestyle, provides for values and character development, engages the chronic user or addict in active participation, matches specific services to specific needs, and continues needed services for an adequate time period.

The results of treatment are well established. Drug and alcohol abusing and dependent people who participate in treatment, when compared to those who do not, decrease their use, decrease their criminal activity, increase their employment, improve their social and interpersonal functioning, and improve their physical health. Drug use and criminal activity decrease for most who enter treatment, with increasingly better results for those who remain in treatment for a significant period of time.

Intensive (often-residential) drug treatment or therapy is essential for many abusers and addicts but may be of variable duration. The services that prepare the addict for recovery and support continuing recovery, while less expensive, are invariably of long duration. The provision of case management services, vocational skills, social survival skills, relapse prevention skills, and medical attention will all be necessary to some extent, to allow the continuation of the process that begins with intensive treatment. During this transitional, or "aftercare" period, self-help groups, faith-based programs, culture-based programs, and other community groups can offer the structure, sanctions, and support that are so critically

needed to sustain recovery. Such programs are distinct from formal treatment and might better be called “recovery” programs.

Thorough and continuous assessment, treatment planning, case management, supervision, and accountability must be integral parts of treatment. Residential treatment programs with carefully planned and executed transitional services, supervision and support have significantly better outcomes than programs without such services. Considerable staff training will be required to incorporate these critical elements.

Treatment for offenders with substance use disorders can be enhanced when there is direct criminal justice involvement. The threat of criminal justice sanction motivates offenders to enter treatment and, perhaps more important, motivates them to stay in treatment for a period of time sufficient for behavior change. However, external threats alone do not appear sufficient for the maintenance of stable recovery, which requires internal motivation. The personalized supervision and positive reinforcement of a community-based team, which includes the judge, can provide encouragement and incentive for offenders. Furthermore, motivational interviewing and other clinical steps to foster treatment engagement are showing promise. In correctional institution settings, effective programs are often provided in a segregated treatment unit to foster engagement.

Offenders with substance use disorders present problems of both substance abuse and criminal behavior. Offenders’ drug dependence can not explain away criminal acts for which they are, and must be held, accountable. This applies equally to recidivism, which is not simply an indication of program failure. For some offenders, drug and alcohol abuse is just one of a number of aberrant behaviors. For others, drug craving, seeking, and using behaviors have virtually taken over their lives. For still others, mental illness is also present. And for almost all, criminal thinking patterns must be confronted as well as drug dependence and mental illness. All contribute to criminality and hinder change.

C. GUIDING PRINCIPLES FOR POLICY

1. Confronting the Myths

Certain myths maintain a strong hold on many policy makers, and hinder the provision of effective treatment. Among them are the following.

"Treatment is soft on criminals." Providing offenders with substance abuse treatment services amounts to leniency in punishment. Offering the offender treatment services undercuts the punishment goals of a sentence.

Furthermore, "Offenders do not deserve treatment." Treatment is a privilege that offenders do not warrant because of their involvement in crime.

Finally, "Treatment can not be offered in prison, jail, or community probation settings." Because substance abuse treatment is a specialized service that addresses underlying behaviors, it can not be offered effectively in punishment environments. At a minimum, services offered in these environments will be compromised

None of these myths holds up under scrutiny. Treatment is hard. The physiological and psychological consequences of substance abuse make it so. Dropout rates are high for those who seek treatment on their own, when they are confronted with what is required of them. Many offenders, given the option, choose to do time rather than work at the personal change that treatment demands. It is also important to note that treatment is not solely, or even primarily, a service for the benefit of offenders with substance use disorders. Although offenders clearly benefit with the acceptance of personal accountability; public safety, public health, and the public purse are the primary beneficiaries of treatment for this population. All suffer when treatment is unavailable, withheld, or poorly delivered.

The question is not whether offenders deserve treatment but whether it is sound practice to release untreated, addicted offenders back into their communities. Personal accountability is essential to long-term recovery and must be practiced in real life settings. Since the vast majority of incarcerated offenders will eventually return to their communities, public safety demands that society: identify those who can be managed in community justice programs without need for incarceration; identify those incarcerated offenders who need treatment; and provide post-incarceration supervision and support.

Regarding the apparent antipathy of the objectives of the treatment and justice systems, actual experience indicates that they can be mutually re-enforcing. Indeed, the research suggests that, among justice interventions, only treatment reduces recidivism. RAND Corporation researcher, Joan Petersilia has reviewed 15 years of experimenting with intermediate sanctions and found that treatment services are the only component that is

effective in reducing recidivism. Earlier studies of boot camps and intensive supervision probation, by the National Institute of Justice, had similar findings. Prison treatment studies, especially for programs with appropriate follow up, yield the same results. Control efforts, including incarceration, monitoring, and drug testing have limited impact by themselves; however, in concert with treatment they can change the behavior of offenders. Without treatment to provide new skills and approaches, long term change in values, attitudes, and behaviors is unlikely to occur.

2. Applying What Science and Experience Have Taught

Given the chronic relapsing nature of addiction, the consequences of addictive behavior for the individual, the family, and society, and the condition of existing service systems, our efforts to prevent and treat addictive disorders should be governed by the following:

- Interventions should increase long-term community safety, reduce long-term threats to public health, and reduce long-term direct and indirect costs to society.

- Interventions should increase order and safety in correctional facilities.

- Interventions should increase personal accountability and responsibility on the part of offenders with substance use disorders.

- Interventions should reduce community factors ("risk" factors) that contribute to substance abuse, and strengthen factors ("protective" factors) that minimize the risk of substance abuse.

- Community and family support systems should be encouraged and assisted;

- Any significant opportunity to get those who abuse alcohol and drugs into a formal treatment and rehabilitation program should be seized. The justice system offers an immediate opportunity to engage significant numbers in treatment and long term recovery.

- Existing public health and justice system interventions -- treatment and rehabilitation, intermediate sanctions, TASC programs, justice treatment networks, drug courts, assessment centers, halfway houses -- should be expanded**;** and the expansion of capacity must be accompanied by training, technical assistance, and formal means (e.g., certification) to assess and ensure competence on the part of treatment providers.

- Newly established treatment programs should develop a comprehensive implementation plan that includes measures to ensure and maintain staff competency.

- Newly established and existing programs should ensure staff competency in the following content areas: foundations for the addictions profession; clinical evaluation; treatment planning; referral; case management; client, family, and community education; documentation; and professional/ethical responsibilities.

- Programs working with criminal justice populations should ensure staff competency in the following areas: dynamics of addiction and criminal behavior; legal, ethical and professional responsibility; criminal justice system and processes; screening, intake, and assessment; case management, monitoring, and client supervision; and counseling.[23]

- All treatment programs should employ a comprehensive assessment instrument at the point of intake, and update that assessment periodically during the course of treatment and patient recovery. Furthermore, programs should incorporate performance measures to assess offender progress toward clearly defined goals and objectives and respond to progress or the lack thereof, with appropriate incentives and sanctions.

- All treatment programs should assess and address life skills deficits and mental and primary heath problems, involving the offender's family to the extent possible and appropriate.

- All treatment programs should develop a formal, long-term treatment plan, in accordance with the results of the assessment; and review and revise it with periodic assessments.

- All treatment programs should recognize and respond to differences in gender, age, and ethnicity or culture.

- Programs should consider cognitive behavioral and social learning models that have been demonstrated to be effective in changing the behavior of offenders. Social learning models that confront criminal thinking patterns and teach offenders problem solving skills, socialization, pro-social values, and the restructuring of thoughts and actions are effective in reducing recidivism.

- All formal treatment interventions should include orientation, compliance motivation training, and relapse prevention training in a phased course of treatment and recovery support.

- Sanctions for non-compliance and rewards for compliance should be established clearly, should be graduated and employed swiftly and fairly.

- Treatment programs should be held accountable for results, in light of the relative difficulty of the population they serve, as determined by the initial, comprehensive assessment. Potential indicators include retention, substance use, dealing, relapse, and criminal recidivism.

- A formal supervision and support function should be designated for each person who completes the initial stage of treatment, to provide management and supervision and ensure continuing compliance with the treatment plan during the period of transition and reentry into the community.

D. RESEARCH AND TECHNICAL ASSISTANCE PRIORITIES

Community actions to establish and implement sound policy require the support of continuing research, technical assistance, and training. The following outline addresses topics of priority importance identified by government and non-government agencies.

1. Research

- Initiate improvements in the dissemination of best practices, including the provision of step-by-step implementation manuals.

- Conduct process research and evaluations and publish guidance on ways to increase retention in treatment; ways to reduce relapse; ways to conduct treatment that foster progress from external coercion to internal motivation.

- Conduct process and outcome research and evaluations, and publish guidance on the provision of substance abuse treatment to juvenile justice populations.

- Conduct research and demonstrations on the development and application of pharmacotherapies and behavioral therapies for the treatment of dependence on/abuse of cocaine/crack, opiates, marijuana, and stimulants including methamphetamine.

- Conduct evaluations and disseminate guidance regarding low-cost treatment and self-help transitional and follow up support (e.g., social model programs, safe and sober houses).

- Conduct long-term longitudinal studies of treatment at all stages of the criminal and juvenile justice systems.

- Evaluate the effectiveness of treatment and supervision programs for adults and juveniles designed to be culturally, gender and developmentally appropriate.

- Evaluate integrated mental health and substance abuse approaches for juveniles and adults with co-occurring disorders.

- Evaluate the impact of family involvement, and the family as the unit of treatment.

- Evaluate rehabilitation programs that include comprehensive skills building, job training directly linked to employment, and viable education programs.

- Evaluate cognitive behavioral approaches for juveniles.

2. Technical Assistance

Provide a range of technical and program development assistance services to facilitate the acceptance and implementation of best practices, and professional staff development, for treatment and supervision.

- Mentor sites
- Intergovernmental and interagency websites
- Best practices manuals and other guidance publications (ongoing interagency series)
- National and regional conferences and workshops (ongoing series)
- Training institutes
- On- and off-site technical assistance

E. PERFORMANCE MEASURES OF EFFECTIVENESS

The *National Drug Control Strategy*'s purpose is to reduce drug use and availability by 50 percent by 2007. It seeks to reduce drug-related crime and violence by 15 percent before the year 2002 and 30 percent by the year 2007. Reducing drug consumption by chronic users is one of the most promising ways to decrease this crime. ONDCP has developed, in coordination with all federal drug control program agencies, ninety-four measurable targets to gauge progress towards these five- and ten-year objectives. The measures that are directly related to this initiative include:

Drug-related violent crime. By 2002, achieve a 20 percent reduction in the rate of homicides, robberies, rapes, assaults, and crimes against property associated with illegal drugs as compared to the 1996 base year. By 2007, achieve at least a 40-percent reduction

Drugs and recidivism. By 2002, reduce by 10 percent the proportion of identified drug-using offenders who are rearrested for new felonies or serious misdemeanors within a 1-year period following their release from supervision using 1998 as the base year. By 2007, reduce this proportion by at least 25 percent.

Inmate access to illegal drugs. By 2002, reduce by 25 percent the proportion of inmates who test positive for illegal drugs during their incarceration in Federal, State, county, or local detention facilities as compared to the positive test rate in the 1997 base year. By 2007, reduce positive tests by 50 percent.

Drug testing policies. By 1999, in concert with the States, adopt drug testing policies within the criminal justice system which**: clearly** articulate the purposes and goals of drug testing; and prescribe responses; target appropriate populations based in an assessment of need for each type of drug; specify testing types and frequency; specify how offenders will be targeted for testing; and detail staff training requirements.

Positive drug test responses. By 1999, in concert with State correctional agencies and local correction offices, adopt processes to ensure that there is a response to every positive test or assessment of need; including event documentation, enhanced case management, increased judicial supervision, or imposition of other graduated sanction and treatment interventions.

Treatment availability. By 2002, increase by 10 percent the proportion of identified drug-using offenders who are provided substance abuse treatment interventions as compared to the 1997 base year. By 2007, increase this proportion by at least 25 percent.

Breaking-the-Cycle ("BTC") demonstration projects. By 2000, increase the number of juvenile and adult sites demonstrating the principles embodied in the "BTC" research demonstration project. By 2001, refine the BTC research demonstration project and develop revised models for State and local governments.

Drug-crime focused court reform. By 2002, 60 percent of the States and metropolitan areas (as defined by the U.S. Census Bureau) will implement drug-crime based judicial reform or specialization of the courts system to elicit a decrease in drug-crime recidivism. By 2007, 80 percent of States and metropolitan areas will show a decrease in the recidivism rate compared to the base year.

Effectiveness study. By 2002, research the relative success of law enforcement and disseminate this information to at least 80 percent of law enforcement or drug prevention and treatment agencies. By 2007, ensure all related agencies have received the research findings and 90 percent have implemented selected initiatives.

F. ACKNOWLEDGEMENTS, BIBLIOGRAPHY, AND ENDNOTES

1. Summit Participants

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of 20.4 months. These numbers show that the time served in prison by Federal drug offenders more than doubled between 1986 and 1998. Lastly, from 1997 to 1998, those Federal offenders sentenced for drug trafficking served an average of 41.9 months in prison, while those sentenced for possession and other drug offenses served an average of 11.2 months. [5] U.S. Department of Justice, Office of Justice Programs. Bureau of Justice Statistics. *Compendium of Federal Justice Statistics, 1998*. NCJ-180258. May 2000. [5] U.S. Department of Justice, Office of Justice Programs. Bureau of Justice Statistics.*Time Served in Prison by Federal Offenders, 1986-1997*. NCJ-171682. June 1999.

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percent receiving some form of treatment (range 2.1 to 45.3 percent), and 14.2 percent completing treatment before release from prison. A conservative 50 percent estimate yields about 2.5 million people in need of treatment. The most generous estimate of the percent of probationers receiving any treatment, by BJS for 1995, found 38 percent (most for alcohol). The BJS estimate for prisons in 1997 was 20 percent. Without any consideration of the quality of the programs being offered, a very conservative estimate would be that over a million offenders under criminal justice supervision need, and are not getting, drug treatment (500,000 probationers, 350,000 prisoners, and 160,000 jail inmates).

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