SECOND CHANCE ACT OF 2005 (PART II): AN EXAMINATION OF DRUG TREATMENT PROGRAMS NEEDED TO ENSURE SUCCESSFUL RE-ENTRY

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

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HOUSE OF REPRESENTATIVES

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SECOND CHANCE ACT OF 2005 (PART II): AN EXAMINATION OF DRUG TREATMENT PROGRAMS NEEDED TO ENSURE SUCCESSFUL RE-ENTRY

WEDNESDAY, FEBRUARY 8, 2006

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 4 p.m., in Room 2141, Rayburn House Office Building, the Honorable Howard Coble (Chair of the Subcommittee) presiding.

Mr. COBLE. Good afternoon, ladies and gentlemen. I want to welcome each of you to an important hearing to examine the issue of drug treatment programs and prisoner re-entry.

At the outset, I want to thank Mr. Bobby Scott, the Ranking Member, and his counsel Mr. Vassar, for their cooperation and support, as well as our counsel Mike, for this hearing and, Bobby, for your commitment to broaden H.R. 1704, the Second Chance Act to include drug treatment and other innovative programs. The Second Chance Act is a unique proposal which, if enacted, will reduce crime, promote community safety, and give offenders a true second chance in life.

In my opinion, if an offender has paid his or her debt to society, it is incumbent on the Government to give these offenders a true second chance to become law-abiding and productive members of society. After all, in many cases we are talking about people who truly need a second chance, people who are in need of jobs, education, drug treatment, and other assistance so that they can help themselves maintain their families and better their communities.

Today we are focusing on the issue of drug treatment for offenders. The statistics of the drug problem and offenders are staggering. Fifty-seven percent of Federal and 70 percent of State inmates have used drugs regularly prior to prison, with some estimates of offender involvement with drugs or alcohol around the time of offense as high as 84 percent. The Bureau of Justice Statistics Trends in State Parole, 1990–2000, 60 to 83 percent of the Nation's correctional population have used drugs at some point in their lives. A Bureau of Justice Statistics analysis further indicates that only 33 percent of Federal and 36 percent of State inmates have participated in residential inpatient treatment programs for alcohol and drug abuse 12 months prior to their release.

The problem must be addressed. Any offender re-entry strategy has to include comprehensive and innovative drug treatment programs. The President has stated his support for increasing drug treatment on numerous occasions. In 2002, President Bush explained we must aggressively promote drug treatment because a nation that is tough on drugs must also be compassionate to those addicted to drugs.

Today there are 3.9 million drug users in America who need, but who do not receive, help. And we have to do something about that problem.

As we examine innovative drug treatment programs, I want to emphasize to everyone what I believe should be the single and most important question: Is there evidence that such a program works? If so, I would like to look at the need for such a drug treatment program in a particular setting, how such a program fits into an overall comprehensive approach to re-entry, maintaining continuous care, and how high a priority should we place upon authorizing such a drug treatment program.

I want to reiterate my commitment to working with my good friend Bobby Scott and the other colleagues who are involved in this matter, so that we can bring to the full Committee, hopefully, a comprehensive approach to the re-entry problem.

I look forward to hearing from today's witnesses about new and innovative drug treatment programs. I am now pleased to yield to the Ranking Member, the distinguished gentleman from Virginia, Mr. Bobby Scott.

Mr. SCOTT. Thank you, Mr. Chairman. And I want to welcome Greg Barnes, who is substituting for Bobby Vassar today. He is out with the ATF—somewhere out in never-never land.

Mr. COBLE. If the gentleman will yield. I think my counsel may have blown the whistle on Bobby earlier today.

Mr. SCOTT. Well, anyway, I thank you for your dedication in developing an effective prisoner re-entry system in this country and for the bipartisan, open-minded approach you and your staff, particularly Mike, have taken in so doing. I would also like to thank you for holding this second hearing this Congress on prisoner re-entry issues and in particular for this hearing emphasizing the importance of drug treatment and assuring that released offenders remain crime-free and live productive lives.

I fully expect that today we will hear what has been clear for some time, that drug treatment for returning offenders greatly reduces recidivism and saves more money than it costs in avoided law enforcement and incarceration expenditures. And while assisting returning offenders is a cost-effective reason to develop and expand effective prisoner re-entry programs, I know that you are aware, as I am, Mr. Chairman, that the most important reason for doing so is because it better assures that members of the public will not have to suffer as victims of crime due to recidivism.

This year, close to 700,000 people will leave prisons in the United States. Most of them are ill-prepared to succeed in earning a living and leading a law-abiding life, and the resources available to assist them are very limited. The addition of a felony record and a prison stay certainly doesn't help them get a job. Prisoners are released with limited education, limited resources and job skills,

disqualifications from many Federal benefits due to drug or other convictions, often no family or community support. So it is not surprising that as many as two-thirds of the released prisoners are rearrested for new crimes within 3 years of their release.

Although the national crime rate has fallen significantly over the last decade, we are seeing a continuing and unprecedented increase in our prison and jail population. All of this focus on increasing sentences has led us to the point where we now have on a daily basis approximately two and a half million people locked up in our Nation's jails and prisons, a fivefold increase over the past 20 years. As a result of this focus on incarceration, the United States is now the world's leader in incarceration. The rate per 100,000 population is approximately 142 in England, 117 in Australia, 116 in Canada, 91 in Germany, and 85 in France. We are by far the largest incarcerator, with a rate of 726 per 100,000 in 2004. The closest competitor is Russia, with 532.

Despite all our tough sentences, over 95 percent of inmates will be released at some point. The question is whether they will reenter society in a context that better prepares them and assists them to lead law-abiding lives or continue the cycle of two-thirds of them returning in 3 years. So if we are going to continue to send more and more people to prison with longer and longer sentences, we should at least do as much as we reasonably can to assure that when they do return, they won't go back to prison with new crimes.

Mr. Chairman, I expect that we will see from the testimony today that we have the experience, the evidence, and experts to show that we can reduce recidivism through smart re-entry programming. What's needed are the resources to carry out that programming. The Second Chance Act, of which you and I are both cosponsors, is a bipartisan bill supported by a broad coalition of organizations and individuals, liberals and conservatives, who recognize the importance of moving forward on this issue. We also have the LERA bill, the Literacy, Education, and Rehabilitation Act, which is also designed to reduce recidivism.

I believe that this hearing provides an important part of the foundation for our taking this next step toward passing a well-founded, effective re-entry bill, and I look forward to the testimony of the witnesses today to help us in this process.

Mr. Chairman, we can protect the public by reducing the chance that prisoners will come back and commit new crimes by passing the legislation that we will be hearing about today.

Thank you, Mr. Chairman.

Mr. COBLE. I thank the gentleman from Virginia. And we have also been joined by the distinguished gentleman from Ohio. Mr. Chabot, good to have you with us today.

For the benefit of the witnesses, it is the practice of the Subcommittee to swear in all witnesses appearing before it. So if you all would please stand and raise your right hands.

[Witnesses sworn.]

Mr. COBLE. Let the record show that each of the witnesses answered in the affirmative.

We have four distinguished witnesses with us today. Our first witness is Dr. Nora Volkow, director of the National Institute on Drug Abuse, NIDA. Dr. Volkow is the first woman to serve as

NIDA's director since the founding of the institute. Prior to joining NIDA, Dr. Volkow held concurrent positions at the Brookhaven National Laboratory as Associate Director for Life Sciences and Director of Nuclear Medicine. She is a recognized expert on the brain's dopamine system and was the first to use imaging to investigate neurochemical changes that occur during drug addiction.

Dr. Volkow received her B.A. from Modern American School, an M.D. from the National University of Mexico, and post-doctoral training in psychiatry at New York University.

I am going to ask Mr. Scott if he will introduce his fellow Virginian.

Mr. SCOTT. Thank you, Mr. Chairman. Our second witness will be Kenneth Batten, who is the Director of the Office of Substance Abuse Services at the Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services. He serves as the Single State Authority for Substance Abuse for the Commonwealth. He has extensive work experience with substance abuse populations.

Previously, he worked as the Director of the Division of Substance Abuse Services and Chief Case Manager at the Commission of the Virginia Alcohol Safety Action Program. He is a member of the National Association of State Alcohol and Drug Abuse Directors and serves as chair of the Criminal Justice Committee, and is testifying in that capacity.

He is a graduate of Morris Harvey College and the Virginia Commonwealth University.

I am pleased to have a fellow Virginian here testifying with us today.

Mr. COBLE. Thank you, Mr. Scott, Mr. Batten, Doctor.

Our third witness is Ms. Pamela Rodriguez, Executive Director at the Treatment Alternatives for Safe Communities, TASC. While at TASC, Ms. Rodriguez is responsible for TASC research, policy, and legislative activities and for the implementation of a broad array of programs, including corrections and re-entry strategies, mental and drug health courts, and testing and counseling. Additionally, Ms. Rodriguez has performed consultations and training on a State and national level with regard to systems development in corrections, criminal justice, child welfare, and treatment services.

She received her undergraduate degree from Bemidji State University—where is that, Ms. Rodriguez?

Ms. RODRIGUEZ. Northern Minnesota.

Mr. COBLE. Northern Minnesota—an M.A. from the University of Chicago.

Our final witness today is Ms. Lorna Hogan, Associate Director of Sacred Authority Program at the Rebecca Project for Human Rights. Mrs. Hogan is the mother of four children and celebrates 5 years clean of drugs. She attributes her recovery and the end of her drug-related criminal activities to a comprehensive family-based treatment program where she and her children were allowed to heal together. Ms. Hogan is a recent graduate of Montgomery College's Continuing Education Program, and is an active PTA mom.

We look forward to hearing from you, Ms. Hogan, and your compelling story before our Subcommittee today.

Now, folks, the only thing Mr. Scott and I are inflexible about is we try to abide by the 5-minute rule. If you all see the amber light appear on your panel, that is your warning that the ice on which you are skating is getting thin. You will have 1 minute after that. Now, we're not going to—anybody if you are not done after 5 minutes, but when the red light appears, that is your signal that the 5 minutes have expired. We have read your written testimony, and I am sure that will be re-read subsequently.

Dr. Volkow, if you will start us off.

TESTIMONY OF DR. NORA VOLKOW, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, NATIONAL INSTITUTES OF HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. VOLKOW. Yes, good afternoon, Mr. Chairman and Members of the Subcommittee. It is a privilege to be here to discuss NIDA's research on the importance of drug abuse treatment in the criminal justice system.

Research has consistently shown that drug abuse treatment in the criminal justice setting and upon re-entry to the community is cost-effective and markedly reduces recidivism into both drug abuse and incarceration. Considering that close to .5 million Americans are incarcerated and that more than half of these are regular drug users, we have a major opportunity for improving public health and public safety.

Drug addiction is a disease of the brain that affects the circuits involved in processing punishment and reward and in exerting inhibitory control. As a result, the addicted person will seek drugs compulsively even when they consciously don't want to and despite the threat of severe punishment, such as incarceration and loss of child custody, and at the expense of natural reinforcers, such as family and friends.

Addiction can be treated, and its treatment does not need to be voluntary to be effective. This is why instituting treatment in the criminal justice setting constitutes such an extraordinary public health opportunity.

However, for treatment to be effective, it has to be comprehensive and address the various elements in the person's life that has been disrupted by drugs—family, employment, education, and health. Thus, successful outcomes can be achieved with criminal offenders who receive treatment in prisons, provided that a comprehensive aftercare component is included during the transition back into the community.

For example, in one study, those who participated in prison-based treatment followed by aftercare were seven times more likely to be drug-free and two times more likely to be arrest-free after 3 years than those who received no treatment.

Another unique opportunity is reaching young offenders, since an appropriate therapeutic intervention can shift their life trajectories from one of failure to one of success. Age matters when it comes to drug abuse, since exposure to drugs during adolescence or childhood may adversely affect brain development and increase the vul-

nerability to drugs. A therapeutic intervention at this stage of life, when the disease of addiction is still of recent onset, is more likely to be successful than during adulthood, when it's much more chronic.

Though we have shown through science that treatment for drug addiction works, a big challenge is its implementation. For example, medications have been shown to help normalize brain function, such as is the case of methadone and buprenophrine when using the treatment for heroin addiction. Yet these medications are all but absent in the criminal justice system.

The translation of science to practice in the criminal justice setting is complicated by the need to merge two very different cultures—the public health one that aims to treat, and the public safety that aims to protect the community. Thus, a priority for NIDA has been to develop research to help translate findings from treatment research into the criminal justice setting.

One such example is the creation of our research networks, which we call the CJ-DATS, done in collaboration with the Department of Justice and SAMHSA, that includes researchers working with treatment providers as well as prisons in several locations throughout the United States. And this network allows us to evaluate treatment interventions for drug abuse in criminal offenders while in prison and upon community re-entry.

Further, because African American males are over eight times more likely to be incarcerated than white males, research on the criminal justice consequences of drug abuse in the African American population is a priority for NIDA.

Treatment of the drug offender during incarceration and re-entry to the community directly benefits not only the addicted person, his or her family, but also the community. Returning a sober parent gives a child the confidence brought by the protection of the family. Providing medical treatment to the abuser can reduce transmission of infectious diseases such as HIV and hepatitis, which are twice as prevalent in this population. And of course, reducing crime benefits the whole community.

Treatment of the drug-abusing offender is not only a necessity for the individual's recovery, but it is also an urgent public health issue. And because it's cost-effective, it's a win-win both for public health and for public safety.

I will be happy to answer any questions you may have.

[The prepared statement of Dr. Volkow follows:]

PREPARED STATEMENT OF NORA D. VOLKOW

Testimony
Before the Subcommittee on Crime, Terrorism, and Homeland Security
Committee on the Judiciary
United States House of Representatives

An Examination of Drug Treatment Programs Needed to Ensure Successful Re-entry

Statement of
Nora D. Volkow, M.D.
Director, National Institute on Drug Abuse
National Institutes of Health
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 4:00 p.m.
Wednesday, February 8, 2006

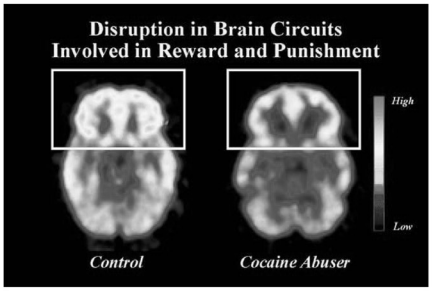
Mr. Chairman and Members of the Committee:

Thank you for inviting the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), an agency of the Department of Health and Human Services (HHS), to participate in this important hearing. As the world's largest supporter of research on drug abuse and addiction, we have learned much about the importance of drug treatment in helping people recover from this devastating disease. Our work extends to all segments of society, including the criminal justice system, where our research shows the pivotal role that drug treatment can play in breaking the vicious cycle of drug abuse and criminal behavior—particularly during the vulnerable period of re-entry into the community. In that regard, securing drug treatment for criminal offenders with drug problems extends beyond the individual to become an issue of public health and safety. I am pleased to be here today to present an overview of what the science has taught us about drug abuse treatment and to highlight effective treatment approaches, targeting intervention opportunities presented by the criminal justice system.

Nearly 7 million adults are involved in the criminal justice system in some way, with more than half of the nearly 2.3 million persons incarcerated having used drugs regularly before their incarceration. However, fewer than 18 percent of these incarcerated offenders received drug treatment either during or after their incarceration.

Among juveniles, too, the problem is serious and growing. In 2002, approximately 1.6 million youth were involved in the juvenile justice system,[1] with 60 percent of boys and nearly half of detained girls testing positive for drug use.

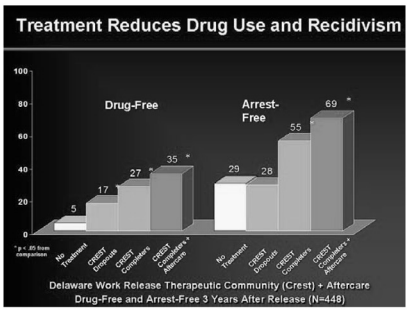
This is the overwhelming reality—but the Administration is proactively working to change it. At NIDA. efforts to integrate evidence-based interventions into practice—in this case drug treatment—reflect a major tenet of our mission. NIDA's research serves to inform important Administration programs such as the Access to Recovery program of HHS's Substance Abuse and Mental Health Services Administration and the Prisoner Re-entry Program, led by the Department of Labor in partnership with the Departments of Justice and Housing and Urban Development. To achieve this aim, our rich criminal justice research portfolio seeks first to understand justice and treatment systems, and then to improve current practice by developing and testing new intervention models.



One old concept has been proven false, for we now know that "forced abstinence" from drug use during incarceration, if abstinence occurs, does NOT alleviate addiction. Research shows that effective treatment of addiction—a chronic, relapsing disease of the brain, characterized by compulsive behavior—requires addressing underlying issues and causes. Because drug addiction compromises the circuits involved in processing punishment and reward and in exerting control over one's actions, the addicted person will compulsively seek drugs despite the threat of severe punishment (e.g., incarceration, loss of child custody), at the expense of natural rewards, such as that from family and friends, and even when they consciously do not want to do it. Comprehensive drug abuse treatment therefore offers the best alternative for interrupting the vicious drug use–criminal justice cycle once a person gets caught up in it.

[1] http://ojjdp.ncjrs.org/ojstatbb/court/JCSCF_Display.asp?ID=qa06601&year=2002&group=1&type=2

Why Treatment Should be Provided to Offenders with Drug Disorders



For Public Health and Safety. We know that drug use increases the likelihood of criminal behavior. In fact, offender drug use is involved in more than half of all violent crimes, in 60-80 percent of child abuse and neglect cases, and, not surprising, in 75 percent of drug dealing and manufacturing cases. Moreover, illicit drug use costs this country about $180 billion a year in crime, productivity loss, health care, incarceration, and drug enforcement.[2] Uninterrupted, the drug abuse-crime cycle jeopardizes public health and public safety and taxes an already over-burdened criminal justice system. It follows then that reducing drug use can reduce crime and improve not just the health, safety, and well-being of the individual, but of communities and society as a whole.

Treatment Works! NIDA's research findings show unequivocally that drug treatment *works* and that this is true even for individuals who enter treatment under legal mandate. Interestingly, their outcomes are as favorable as those who enter treatment voluntarily. For example, there is evidence that drug courts—by offering offenders the alternative of community-based treatment instead of incarceration—are promising in reducing criminal behavior and substance abuse.

Effective drug abuse treatment for this population progresses along a continuum that begins in prison and is sustained after release through participation in community treatment programs. Stress is a major risk factor for relapse to drug use and must be taken into account when a substance abuser is making the difficult transition back into society. Therefore, developing a continuum of care is essential to get the best results from drug treatment. To illustrate, in a Delaware Work Release study sponsored by NIDA, those who participated in prison-based treatment followed by aftercare were seven times more likely to be drug free after 3 years than those who received no treatment. Moreover, nearly 70 percent of those in the comprehensive drug treatment group remained arrest-free after 3 years—compared to only 30 percent in the no-treatment group. Studies in California and Texas report similar findings. Drug abuse treatment is an effective intervention for many offenders with substance abuse problems because it can help change attitudes, beliefs, and behavior with regard both to drug use and criminality.

What Constitutes Effective Drug Abuse Treatment?

Effective drug abuse intervention programs are individualized and dynamic, attending and adjusting to the multiple needs of people with co-occurring conditions such as mental illness and other issues, involving both behavioral and pharmacological approaches. Because of the relapsing nature of the disease, there must also be an appreciation of recovery as a long-term process that may require multiple treatment episodes.

The following are some specific aspects of drug abuse treatment that should inform customized treatment strategies.

- *Behavioral Therapy.* Evidence-based interventions include cognitive behavioral therapy to help participants learn positive social and coping skills and to utilize contingency management approaches with them to reinforce positive change. Motivational enhancement through the provision of abstinence-based incentives can increase

2 Office of National Drug Control Policy (2004). The Economic Costs of Drug Abuse in the United States, 1992-2002. Washington, DC: Executive Office of the President (Publication No. 207303).

engagement and retention. A goal of treatment planning should be to match evidence-based interventions to individual needs at each stage of drug treatment.

- *The Case for Pharmacotherapies*. Effective interventions often include pharmacotherapies, or medicines targeting drug abuse and addiction. We at NIDA are hopeful that just as psychotropic medications for conditions like depression or psychosis are starting to be used in criminal justice settings, medications proven effective in treating the disease of addiction can also become part of a comprehensive treatment regimen. Presently, though, despite evidence of their effectiveness, addiction medications are under-utilized and are all but absent within offender populations. For the offender with both mental and substance use disorders, effective use of pharmacotherapies can be instrumental in his or her ability to function successfully in society.

- *Consideration of Co-morbidities.* Comorbid mental disorders are major risk factors for drug abuse and addiction. Children and adolescents with depression, conduct disorder, attention-deficit hyperactivity disorder (ADHD), schizophrenia, or learning disabilities are at much higher risk of abusing drugs than other youth. It is important to adequately assess mental disorders to address them as part of effective drug abuse treatment. Early recognition and treatment of mental illness will help prevent drug abuse, and more effective strategies applied with young people who suffer from co-morbid mental and drug abuse disorders will likely improve their prognosis.

Adolescents and the Juvenile Justice System

We now know that age matters when it comes to drug abuse: exposure to drugs during adolescence or childhood may adversely affect brain development and increase vulnerability to drug effects and addiction. Yet, the inherent plasticity during this period of continued development might also present opportunities for receptivity to interventions that can alter the course of addiction and the course of a young life. Adolescents' involvement with the criminal justice system can provide opportunities to intervene and influence a cycle already in motion. For wherever they enter the system, juveniles often bring with them a number of serious issues—including substance abuse, academic failure, emotional disturbances, family problems, and physical or sexual abuse histories.

The Family-Based Model. Effective treatment of juvenile substance abusers often requires a family-based treatment model that targets family functioning and involvement. Evidence-based interventions supported by NIDA research have shown that these therapies decrease substance abuse and delinquent behavior and are significantly more effective than standard therapies (e.g., peer group therapy) in reducing risk, promoting protective factors, and reducing substance use over the course of treatment.

Family-based models can also help heal the severed bonds between parents and their minor children following incarceration. Sadly, 80 percent of women in state prisons have substance abuse problems, and two-thirds of incarcerated women have minor children. When the bond between a mother and child is broken due to forced separation, a tremendous amount of stress is created, frequently with devastating effects on the child. And because stress can turn the cycle of substance abuse and criminal justice system involvement, these children are placed at increased risk of having substance abuse problems themselves. It is therefore critical to pay attention to the entire family unit and to strive to break this destructive cycle. Through our research on family-based treatment models, NIDA is helping to aid this effort to heal broken bonds and increase family stability.

Disparities Among the African American Population

We are also deeply concerned about the disproportionate impact of drug abuse on African Americans, including those in the criminal justice system. Health disparities among this group are troubling. For while African Americans make up just 13 percent of the U.S. population, they

accounted for more than half of the total AIDS cases diagnosed in 2004. HIV/AIDS is now the leading cause of death among all African Americans 25–44 years old, ahead of heart disease, accidents, cancer, and homicide. And again, the higher rate of HIV infection is not due to higher rates of drug use in this population.

To address these disparities, NIDA is encouraging research that focuses on the nexus of drug abuse, HIV/AIDS, and criminal justice involvement among African Americans to understand the risk factors and pathways between drug abuse and criminal justice involvement, to determine the extent to which criminal justice involvement and HIV/AIDS risk are interlinked or compounded by drug abuse and addiction, and to develop culturally sensitive prevention and treatment programs for drug abuse and HIV/AIDS.

Continuing to Find Solutions through Research and Collaboration

Treatment for drug addiction works, but this knowledge by itself is not sufficient. Implementing drug abuse treatment into any non-treatment setting is challenging. In the criminal justice system, the translation of science to practice is further compounded by the need to merge two very different cultures; public health that aims to treat the individual and public safety that aims to protect the community. Thus a priority for NIDA has been to develop research to help integrate findings and effective treatment practices from treatment research into criminal justice settings. NIDA supports a robust research portfolio examining the integration of drug treatment into the criminal justice system, including our comprehensive Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) initiative. CJ-DATS is a multi-site set of research studies, in collaboration with Federal, state, and local criminal justice partners, designed to improve outcomes for offenders with substance use disorders by improving the integration of drug abuse treatment with other public health and public safety systems. To successfully re-integrate offenders, we must apply our research results and leverage fruitful collaborations at all levels. Through this comprehensive initiative, we are sponsoring a range of research, looking at everything from adolescents with drug problems to the importance of building interagency cooperation and collaboration.

NIDA research efforts are informing systems everywhere, helping to bridge the gaps between what we know works and what is actually taking place in communities. This includes an initiative to educate judges on the science of drug addiction and treatment to help them better understand and consider the consequences of drug use on the brain and behavior. Reaching out to judges, working with drug courts, optimizing our use of data, and sponsoring a range of research—all are aimed at improving drug abuse services and outcomes for criminal justice populations. Outreach to pivotal members of society helps to educate them about substance abuse disorders and to bring about a more integrated and compassionate system that addresses the reality of co-occurring diseases and other drug abuse consequences.

Conclusion

In closing, NIH findings indicate that by integrating drug abuse treatment into criminal justice settings in a number of different ways—including as a condition of probation, via drug courts, in prison followed by community-based aftercare, and under parole or probation supervision at re-entry—we can take optimal advantage of both systems. The essential idea is to understand the necessity of treatment, particularly during the transition back to community. Just because a person has been kept from using drugs does not mean they have gained the necessary skills to build a successful drug-free life in the community. Drug addiction may re-emerge following release from incarceration, at which time continued care is not only a necessity for the individual's recovery, it becomes a public health and safety issue for us all.

Thank you for allowing me to share this information with you. I will be happy to answer any questions you may have.

Mr. COBLE. Thank you, Doctor.
Mr. Batten.

TESTIMONY OF KEN BATTEN, DIRECTOR, OFFICE OF SUBSTANCE ABUSE SERVICES, VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION & SUBSTANCE ABUSE SERVICES

Mr. BATTEN. Chairman Coble, Ranking Member Scott, and Members of the Subcommittee, my name is Ken Batten and I serve as the Single State Authority for Substance Abuse, or SSA, for the Commonwealth of Virginia. Today I appear before you as a representative of the National Association of State Alcohol and Drug Abuse Directors, where I serve as chair of the Criminal Justice Committee.

Thank you for holding this hearing today. I sincerely appreciate the focus this Subcommittee has placed on substance abuse treatment as a key part in offender re-entry programs. As the SSA in Virginia, I manage the publicly funded substance abuse system. I work closely with my counterparts in Virginia and the criminal justice system on treatment and other re-entry issues.

As you know, re-entering offenders face many challenges. There is no doubt that a comprehensive approach is necessary to address the needs of those returning to our communities. Substance abuse treatment must take a prominent role when dealing with issues of re-entry. It is estimated that 70 to 80 percent of the State prisoners have histories of substance abuse; however, as few as 10 percent are receiving formal substance abuse treatment while incarcerated. Their resources for treatment are limited. Research shows us that people can and do recover from addiction and that treatment works.

Our experience with prison and jail-based substance use disorder programs in Virginia also demonstrate the efficacy of these programs in reducing recidivism. A survey of Virginia sheriffs, providers of substance abuse services, and jail services staff has indicated that the establishment of these counseling services by our agency had a significant impact on the behavior of individuals with substance abuse problems in Virginia's jails.

For this hearing I would like to offer the five core recommendations as you consider action on offender re-entry.

Recommendation 1: Coordinate with the Single State Authorities on re-entry strategies. As previously stated, a comprehensive approach must be taken when building a re-entry strategy. Creating a State-level coordinating committee of all necessary agencies and departments helps to identify overlapping services and populations and increase communication among agencies. It is imperative that State substance abuse directors are included in the planning, implementing, and evaluating of any re-entry strategy. The Single State Authorities have the front-line responsibility for managing our Nation's publicly funded substance abuse prevention and treatment system and creating statewide systems of care. Our own experience in Virginia has demonstrated that when these systems coordinate their efforts, less duplication of effort occurs, the overall product improves, and better services are delivered.

Recommendation 2: Expand access to treatment. It has been shown that in order to capitalize on jail and prison substance use disorder programs, it is critical to engage offenders in continuing care upon release; the majority of offenders who seek aftercare services, however, will face a publicly funded system already at capacity. To accommodate the number of people in need, policies that ensure access to and resources for treatment services are necessary in order for State systems to be able to absorb additional admissions. One example is a strong commitment to the Substance Abuse Prevention and Treatment Block Grant, which directs funding to every State and territory. Other support comes from the Department of Justice through programs such as Drug Courts, the Byrne/Justice Assistance Grants, and the Residential Substance Abuse Treatment Program.

Recommendation Number 3: Ensure clinically appropriate care. The research findings of the National Institute of Drug Abuse classifies substance abuse as a brain disease, recognizing that effective drug and alcohol treatment should contain both medical and behavioral therapy components in addition to a broad array of social support services. SSAs are responsible for developing and enforcing treatment standards based upon research and practical experience unique to their State's organizational structure and the individual's treatment needs. State licensure and certification laws help protect the consumer from receiving inappropriate or substandard care.

Recommendation Number 4: Build accountability and outcomes data. Coordination with the State substance abuse agencies also improves accountability. Currently, many Federal grants to address substance abuse treatment do not require a link to the State agencies for purposes of reporting client-level data to a central repository. It is important for common standards, like those developed within the national outcome measures, be used when collecting data in order for findings and outcomes to be complete. Collecting accurate data and sharing information can help improve collaboration, document treatment effectiveness, and maintain a continuous quality improvement approach to managing public resources. It is also essential to use the data collected and conduct additional research on the impact addiction services have on offender re-entry. NASADAD strongly supports the work of the National Institute on Drug Abuse led by Dr. Volkow and encourages collaboration with the National Institute of Justice and Justice Statistics.

Our final recommendation, Number 5: Support efforts like the Second Chance Act. NASADAD strongly supports the Second Chance Act. This legislation lays the foundation of the comprehensive approach I mentioned before that is necessary to address offender re-entry. As you examine further actions regarding re-entry, NASADAD hopes you move forward on this legislation and offers our support on this important issue.

Once again, I would like to thank the Subcommittee for inviting me here today to testify on the State substance abuse programs and their role in offender re-entry. I appreciate the opportunity to share with you my experiences and would be happy to answer any questions.

[The prepared statement of Mr. Batten follows:]

PREPARED STATEMENT OF KEN BATTEN

INTRODUCTION

Chairman Coble, Ranking Member Scott, Members of the Subcommittee, my name is Ken Batten, and I serve as the Single State Authority for Substance Abuse (SSA) for the Commonwealth of Virginia. I am also a member of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), where I serve as Chair of the Criminal Justice Committee.

Thank you for holding this hearing today regarding offender reentry and substance abuse treatment and its impact on American families and communities. I sincerely appreciate the focus this Subcommittee has placed on substance abuse treatment as a key part in offender reentry programs. As you examine further actions regarding reentry, we offer our support and commitment and look forward to working with you and others on this important issue.

CORE RECOMMENDATIONS

There is no doubt that a comprehensive approach is necessary to address the needs of those leaving our jails and prisons and returning to our communities. Entities beyond corrections, including schools, child welfare representatives, businesses, and others must work together to address all the needs of reentering offenders.

As the Single State Authority for Substance Abuse (SSA) in Virginia, I manage the publicly funded State substance abuse system. I work closely with my counterpart in the Virginia criminal justice system on treatment and other reentry issues. I appreciate the opportunity to share with you my experiences.

For this hearing, I would like to offer the following core recommendations as you consider action on offender reentry:

- **Coordinate with the Single State Authorities for Substance Abuse (SSAs)**
- **Expand Access to Treatment Services**
- **Ensure Clinically Appropriate Care**
- **Promote Accountability and Outcomes Data**
- **Support Efforts Like the Second Chance Act**

OVERVIEW—SCOPE OF THE PROBLEM

Each year nearly 650,000 people are leaving State and federal prisons, many unprepared for their return to society. Reentering offenders face many challenges including substance abuse disorders and other health problems, poor education and job skills and a lack of affordable housing. As a result, nearly two-thirds of released prisoners will be rearrested within three years.

The need for comprehensive reentry programs is clear. Successful programs, which include a strong addiction treatment component—increase public safety, save money and improve the lives of the offenders and all in the community.

Substance Abuse is a Distinct, Prominent Problem

It is estimated that 70 to 80 percent of State prisoners have histories of substance use, however, as few as 10 percent are receiving formal substance abuse treatment while incarcerated. Though resources for treatment are limited, research shows us that people can and do recover from addiction and treatment works.

Treatment Reduces Recidivism and Saves Money

Inmates who participate in residential treatment programs while incarcerated have approximately 20 percent lower recidivism rates and 35 percent lower drug relapse rates than their counterparts who receive no treatment in prison (G. Gaes et al, 1999). One study showed that those who completed an in-prison therapeutic community treatment program coupled with aftercare services were significantly less likely to be re-incarcerated: 25 percent of this population was re-incarcerated compared to 64 percent of aftercare dropouts (K. Knight et al, Prison Journal, 1988).

Our experience with prison and jail based substance use disorder programs in Virginia also demonstrates the efficacy of these programs in reducing recidivism. Further, a 1992 Virginia survey of Sheriffs, providers of substance use disorder services and jail services staff indicated that establishment of these counseling services by our agency had a significant impact on the behavior of individuals with substance abuse problems in the jails. Sheriffs reported a 21precent decrease in the number of jail assaults; a 51 percent decrease in the incidence of negative behavior in jails; an improvement of the jail environment; and a 21 percent decrease in the number of suicide attempts in jails.

In addition, treatment saves money. According to the Council of State Governments' (CSG) Reentry Policy Report, for every $1 spent on treatment for offenders, there is up to a $7 crime-related cost savings. Similarly, a study in California found that in spending $209 million on offender treatment, the taxpayers were saved $1.5 billion 18 months later, with the largest savings in crime reduction (D. Gerstein et al, State of CA, 1994).

RECOMMENDATION: COORDINATE WITH SSAS ON REENTRY STRATEGIES

As previously stated, a comprehensive approach must be taken when building a reentry strategy. Creating a State-level coordinating committee of all necessary agencies and departments helps to identify overlapping services and populations and increase communications among agencies. Given the high rate of substance use among offenders and the positive effect of treatment on reducing recidivism rates and saving taxpayer dollars, it is imperative that State substance abuse directors are involved in the planning, implementing, reporting and evaluating of any reentry strategy.

State substance abuse directors have the frontline responsibility for managing our nation's publicly funded substance abuse prevention and treatment system. SSAs have a long history of providing effective and efficient services with the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant housed in the Department of Health and Human Services, serving as the foundation of these efforts. SSAs provide leadership to improve the quality of care; improve client outcomes; increase accountability and nurture new and exciting innovations.

SSAs implement and evaluate a State-wide comprehensive system of clinically appropriate care. They are responsible for setting clinical treatment standards for all addiction treatment services in the States. Every day, SSAs must work with a number of public and private stakeholders given the fact that addiction impacts everything from criminal justice, education, housing, employment and a number of other areas. Lack of coordination with State substance abuse agencies has been a consistent problem with discretionary grants—with the CSG Reentry Policy Report noting that ". . . programs often turn to state agencies for resources when their federal grants expire without giving the state adequate time to plan for the support of such requests."

With a system already facing capacity concerns, should grant programs expire or demand exceed expectation, State substance abuse directors cannot prepare for such situations without direct involvement. As a result, initiatives regarding reentry should closely interact and coordinate with SSAs given their unique role in planning, implementing and evaluating State addiction systems. Our own experience in Virginia has demonstrated that when these systems coordinate their efforts less duplication of effort occurs, the overall product improves and better services are delivered.

RECOMMENDATION: EXPAND ACCESS TO TREATMENT

It has been shown that the most successful outcomes are found for those who received treatment while incarcerated followed up with aftercare services post release. Coordination with SSAs can help provide a seamless transition by ensuring clinically appropriate care while incarcerated and timely access to care once released.

It must be recognized that the majority of offenders who seek aftercare services will enter the publicly-funded system already at capacity leading to waiting lists for services in many areas. In order to capitalize on jail and prison substance use disorder programs however, it is critical to engage offenders in continuing care upon release. Compounding this problem, the National Survey on Drug Use and Health (NSDUH) found that over 20 million Americans needed, but did not receive substance abuse treatment due, in part, to strains on capacity in the publicly funded system. Already, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), the criminal justice system represents the principle source of referral for 36 percent of all substance abuse treatment admissions. To accommodate the number of people in need, every effort must be made to expand prevention and treatment capacity.

Policies that increase access to and resources for treatment services are necessary in order for State systems to be able to absorb additional admissions. One example is a strong commitment to the SAPT Block Grant—funding directed to every State and Territory that represents approximately 40 percent of prevention and treatment expenditures for SSAs. Other support comes out of Department of Justice (DOJ) through programs such as Drug Courts, Byrne/Justice Assistance Grants and the Residential Substance Abuse Treatment (RSAT) program.

Strengthen Prevention Services and Infrastructure

It is also important to remember that infrastructure is needed to provide the capacity and resources for developing efficient and effective programs to prevent and reduce drug related crimes. SAMHSA's Center for Substance Abuse Prevention (CSAP) has been partnering with SSAs to develop this fundamental infrastructure in a number of States through the State Prevention Framework State Incentive Grant (SPFSIG). Other partners in the federal prevention portfolio include the Department of Education's Safe and Drug Free Schools and Communities (SDFSC) State Grants program and Enforcing Underage Drinking Laws (EUDL) housed in the Department of Justice (DOJ).

RECOMMENDATION: ENSURE CLINICALLY APPROPRIATE CARE

The research findings of the National Institute of Drug Abuse (NIDA) classifies substance abuse as a brain disease. Research recognizes that effective drug and alcohol treatment should contain both medical and behavioral therapy components—in addition to a broad array of social support services.

State substance abuse agencies are responsible for developing and enforcing treatment standards for providers. Each State has a unique set of provider standards based on research and practical experience unique to that State's organizational structure and treatment needs. State licensure and certification laws help protect consumers from receiving inappropriate or substandard care.

Studies have shown that clinically appropriate services, including screening, assessment, referral, individualized treatment plans within the appropriate level of care and for the indicated duration of treatment, along with aftercare and other supports, provided by qualified staff help people enter into recovery.

Support the Development of Addiction Workforce

A key challenge for many States in enhancing the quantity and quality of treatment services is recruiting, training, and retaining qualified treatment professionals. Effective addiction counseling is a skill that must be learned and developed. Salaries for counselors average about $30,000 per year, which is low for such skilled and emotionally challenging work.

There is a shortage of trained counselors and that shortage is likely to grow. According to the Bureau of Labor Statistics (BLS), a total of 61,000 individuals were employed as substance abuse and behavioral disorders counselors in 2000; by 2010, the Department of Labor (DOL) projects there will be a need for an additional 21,000 counselors, a 35 percent increase. A similar increase in demand is anticipated for licensed professionals who have received graduate-level educations.

To reverse this trend, initiatives to increase related scholarships and offer student loan repayment must be considered on a State and federal level.

In addition, SAMHSA has funded fourteen Addiction Technology Transfer Centers (ATTCs) that provide training to people working in the field across the nation. The ATTCs are currently involved in a major leadership development initiative. In Virginia, we rely heavily on the Mid-Atlantic ATTC to provide intensive training to prepare entry-level counselors for certification, and to organize our annual week long summer institute staffed by national experts and attended by over 700 addiction professionals.

RECOMMENDATION: BUILD ACCOUNTABILITY AND OUTCOMES

Coordination with the State substance abuse agencies also improves accountability. Currently, many federal grants to address substance abuse treatment do not require a link to the State Agencies for the purpose of reporting client level data to a central repository. It is important for common standards and outcome measurements be used when collecting data in order for findings and outcomes to be accurate and complete. Collecting accurate data and sharing information can help improve collaboration and fine-tune services to better address populations.

Continue technical assistance and support for reporting the National Outcomes Measures (NOMs)

Over the past several years my staff in Virginia has collaborated with staff from SAMHSA and NASADAD to develop outcomes measures to document treatment effectiveness. This process culminated last year with the development of the National Outcomes Measures (NOMs). SAMHSA and the States are working to have all States report NOMs by the end of FY 2007. As we began this process, approximately one-third of the States could initially report NOMs, another one-third could do so with some resources and the remaining States requiring added resources and time.

Virginia was recently awarded a contract to begin reporting NOMs under the State Outcomes Measurement and Management System (SOMMS).

In addition to the NOMs, VaDMHMRSAS has been working to link our client data to data on arrests and employment history at the Virginia State Police and the Virginia Employment Commission. These processes, while maintaining compliance with federal regulations regarding client confidentiality, present exciting opportunities to document treatment effectiveness and maintain a continuous quality improvement approach to managing public resources. Documenting outcomes at the State level will continue to require significant resources to refine state data systems. To maintain recent progress in this area, support for SOMMS and for the Drug Abuse State Information Systems (DASIS) is critical.

Continue to Support Research

It is essential to use the data collected and conduct additional research on the impact addiction services have on offender reentry. SSAs strongly urge the National Institute of Justice (NIJ) and the Bureau of Justice Statistics (BJS) to collaborate with the National Institute on Drug Abuse (NIDA), National Institute of Alcohol Abuse and Alcoholism (NIAAA), and States as they continue studies regarding prisoner reentry efforts. NASADAD applauds NIDA, lead by Dr. Nora Volkov, for working with SSAs and NASADAD to translate research into everyday practice.

RECOMMENDATION: SUPPORT EFFORTS LIKE THE SECOND CHANCE ACT

NASADAD strongly supports the Second Chance Act. This legislation works to increase the availability of treatment and aftercare services by expanding current grant programs and encouraging collaboration among State and federal agencies—including SSAs. The Second Chance Act lays the foundation of the comprehensive approach I mentioned before that is necessary to address offender reentry. It will help establish State level committees to develop well coordinated reentry plans. It also pulls together federal agencies to organize initiatives at the national level as well as a national reentry resource center to disseminate technical assistance and best practices. This will greatly help States and communities share information and knowledge on what works.

CONCLUSION

Once again, I would like to thank the Subcommittee for inviting me here today to testify on State substance abuse systems and their role in offender reentry. I would be happy to answer any questions.

ATTACHMENT

February 2006

National Association of State Alcohol and Drug Abuse Directors, Inc.

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KEY NASADAD POLICY PRIORITIES

- Strengthen State Substance Abuse Systems and the Office of the Single State Authority (SSA)
- Expand Access to Prevention and Treatment Services
- Implement an Outcome and Performance Measurement Data System
- Ensure Clinically Appropriate Care
- Promote Effective Policies Related to Co-occurring Populations

POLICY BRIEF: OFFENDER REENTRY

Overview

Each year over 650,000 people are leaving prison unprepared for their return to society. Many have untreated substance use disorders, lack adequate education and job skills and face homelessness. These factors help explain why, within three years, nearly two-thirds of released prisoners will be rearrested and return to prison.

Vital Role of State Substance Abuse Directors

State substance abuse directors, also known as Single State Authorities (SSAs), have the front line responsibility for managing our nation's publicly funded substance abuse prevention and treatment system. SSAs have a long history of providing effective and efficient services with the Substance Abuse Prevention and Treatment (SAPT) Block Grant serving as the foundation of these efforts. SSAs provide leadership to improve the quality of care; improve client outcomes; increase accountability and nurture new and exciting innovations.

SSAs implement and evaluate a State-wide comprehensive system of clinically appropriate care. Every day, SSAs must work with a number of public and private stakeholders given the fact that addiction impacts everything from education, criminal justice, housing, employment and a number of other areas. As a result, Federal initiatives regarding reentry should closely interact and coordinate with SSAs given their unique role in planning, implementing and evaluating State addiction systems.

Recidivism Rates Drop with Treatment and Aftercare Services

The Council of State Governments' (CSG) Report of the Reentry Policy Council (2005) stated, "substance abuse treatment can reduce both criminal activity and drug use, particularly when in-prison treatment is coupled with community-based aftercare." It is important that corrections administrators work with SSAs in the planning, implementing and evaluating of programs in order to achieve the highest levels of success.

> *"America is the land of second chance, and when the gates of the prison open, the path ahead should lead to a better life."*
>
> *-President George W. Bush, 2004 State of the Union Address*

State Prison Population

- **80%** report histories of drug or alcohol abuse
- **55%** report using drugs or alcohol when committing the crime that resulted in their incarceration
- **90%** have not received formal substance abuse treatment during incarceration
- **75%** recidivate when no treatment is received while incarcerated
- **27%** recidivate when treatment is received while incarcerated
- **$1** spent on treatment yields **$7** in future savings

Addressing Offender Reentry

- Coordinate with Single State Authorities (SSAs) for Substance Abuse
- Expand Access to Treatment
- Strengthen Prevention Services and Infrastructure
- Support the Development of Addiction Workforce
- Continue to Support Research

Coordination with Single State Authority (SSA)

Given the high rate of substance use disorders among offenders reentering our communities and positive effect of treatment on reducing recidivism, it is imperative that SSAs are involved in planning, implementing and evaluating any reentry strategy.

The Residential Substance Abuse Treatment (RSAT) program, housed within the Department of Justice (DOJ), acknowledges the importance of collaboration by requiring grantees to coordinate with SSAs when designing and implementing treatment programs.

> ***As noted by the Council of State Governments' (CSG) Report of the Reentry Policy Council, it is vital to "ensure that individualized, accessible, coordinated, and effective community based substance abuse treatment services are available."***

Expanding Access to Treatment

The National Survey on Drug Use and Health (NSDUH) found that over 20 million Americans needed, but did not receive substance abuse treatment due, in part, to strains on capacity in the publicly funded system. Already, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), the criminal justice system represents the principle source of referral for 36 percent of all substance abuse treatment admissions. With 650,000 offenders returning to our cities and towns, many in need of services, every effort must be made to expand prevention and treatment capacity.

Policies that increase access to treatment services are necessary in order for State systems to be able to absorb additional admissions. One example is a strong commitment to the SAPT Block Grant – funding directed to every State and Territory - that represents approximately 40 percent of prevention and treatment expenditures for SSAs. Other support comes out of DOJ through programs such as RSAT and the Reentry Demonstration Grants.

Strengthen Prevention Services and Infrastructure

Any crime prevention strategy requires a sound alcohol and other drug prevention infrastructure in each State. Infrastructure is needed to provide the capacity and resources for developing effective programs to prevent and reduce alcohol and other drug related crimes. SAMHSA's Center for Substance Abuse Prevention (CSAP) has been partnering with SSAs to develop this fundamental infrastructure in a number of States through the State Prevention Framework State Incentive Grant (SPFSIG).

Support the Development of Addiction Workforce

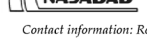
A key challenge for many States in enhancing prevention and treatment services is recruiting, training, and retaining qualified treatment professionals. Effective addiction counseling is a skill that must be learned and developed. Salaries for counselors average about $30,000 per year, which is low for such skilled and emotionally challenging work.

There is a shortage of trained counselors and that shortage is likely to grow. According to the Bureau of Labor Statistics (BLS), a total of 61,000 individuals were employed as substance abuse and behavioral disorders counselors in 2000; by 2010, the Department of Labor (DOL) projects there will be a need for an additional 21,000 counselors, a 35 percent increase. A similar increase in demand is anticipated for licensed professionals who have received graduate-level educations.

To reverse this trend, initiatives to increase scholarships and offer student loan repayment to those working in the field must be considered on a State and federal level.

Continue to Support Research

It is essential to conduct research on the impact addiction services have on offender reentry. SSAs strongly urge the National Institute of Justice (NIJ) and the Bureau of Justice Statistics (BJS) to collaborate with the National Institute on Drug Abuse (NIDA), National Institute of Alcohol Abuse and Alcoholism (NIAAA), and States as they continue studies regarding prisoner reentry efforts.



NASADAD's mission is to promote effective and efficient State substance abuse service systems.

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Mr. COBLE. Thank you, Mr. Batten.
Ms. Rodriguez.

TESTIMONY OF PAMELA RODRIGUEZ, EXECUTIVE VICE PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC), INC.

Ms. RODRIGUEZ. Good afternoon. I would like to thank Chairman Coble, Ranking Member Scott, and the Subcommittee for inviting me to testify today. I am the Executive Vice President of TASC, Treatment Alternatives for Safe Communities. TASC is a statewide not-for-profit organization in Illinois that provides access to recovery and other specialized services for individuals involved in the State's public systems, including criminal justice, corrections, juvenile justice, child welfare, and public aid.

With a total correctional population in the United States at a record high 6.7 million, the problems associated with offender reentry have not gone unnoticed. People on probation and parole face a host of seemingly insurmountable challenges in attempting to achieve stability and successfully reintegrate back into society. It is in the public's best interest to work toward addressing and removing these barriers. Doing so will reduce the costly cycle of crime and recidivism in which so many individuals and communities are entrenched.

While the barriers to successful re-entry are daunting and numerous, there are programs and organizations that achieve positive outcomes in this area. By systemically using evidence-based practices and programs to build on existing infrastructures, the extensive growing problems associated with criminal justice populations can be addressed. People's lives will be changed for the better—not only those who are incarcerated, their families and their communities, but also the American public that expects its taxes to be spent effectively and wants to live without the threat of crime.

TASC programs across the country assist in the achievement of recovery, rehabilitation, and successful re-entry for thousands of people each year. While I'm here representing TASC in Illinois, I would be remiss to neglect mentioning other significant TASC programs that share our goal of improving outcomes for substance abusing offenders and reducing recidivism—like those in Ohio, North Carolina, Alabama, Arizona, Delaware, and New York.

In Illinois, our statewide presence and impact on thousands of offenders each year exemplifies the real possibility of systemic change on a national level. We reach over 30,000 people in our State annually, 4,000 of whom receive transitional clinical case management through our corrections programs. Another 10,000 probationers are served by TASC through alternative sentencing programs. TASC works with an array of service providers and community partners, including treatment recovery support, non-traditional providers, former offenders, and faith-based organizations throughout the State.

Funded by Federal, State, and county governments, an important element of Illinois' offender management infrastructure is the incorporation of an independent case management entity. Research conducted by Thomas McClellan at the Treatment Research Institute in Philadelphia concluded that case management is an effec-

tive tool to use in increasing the appropriateness of and adherence to quality alcohol or drug treatment in public systems.

As Illinois' designated agent to provide case management services to people needing substance abuse treatment or interventions, referred through the court or corrections, TASC utilizes a clinical approach to create a service delivery plan tailored to the unique needs of each individual and is also responsive to the need for offender accountability, public safety, and efficient use of public resources.

And yet, demand for services far exceeds our capacity. The Second Chance Act addresses these issues. TASC is in full support of the Second Chance Act, which will address the current system of barriers to successful integration. This vital legislation will help restore citizenship, promote accountability and responsibility for self that is fundamental to recovery from addiction, encourage family strength and stability, and engage communities in the rehabilitation of their own citizens. For many years, TASC has had the honor of working with Illinois Congressman Danny Davis on these important issues.

The Second Chance Act will provide critical support services that enable ex-offenders to successfully transition back into their communities and stay out of prison and jail by expanding substance abuse and mental health interventions and treatment, job assistance, and housing. It is our hope that this act will build on existing infrastructures, expanding on programs, services, and treatments proven to work. This legislation will promote public safety and save taxpayer dollars by breaking the costly cycle of recidivism that causes individuals, especially those with drug and alcohol issues, to repeatedly offend and serve time in our Nation's prisons and jails. Research shows that $7 in savings is recognized for every dollar invested in treatment. Additionally, research indicates that there's a 40 percent reduction in the costs of incarceration when offenders are served in community-based alternative sentencing programs.

We know that the problems of alcohol and other drug abuse and mental illness are thoroughly intertwined with crime, incarceration, and recidivism. We also know that assessment, intensive clinical case management, intervention and treatment work to reduce drug and alcohol addiction and treat mental health conditions for those involved in the criminal justice system, routinely showing a 50 percent reduction in recidivism when treated. It makes sense to expand the provision of these vital services in prisons and jails and aftercare.

With the Second Chance Act , we have the opportunity to create maximum impact by developing a thoughtful systemic response that expands substance abuse and mental health treatment, safe and supportive housing, education, employment training, family and community assistance. This legislation begins a process for ensuring better coordination and planning and builds on existing infrastructure, leveraging both resources and proven programs. Finally, with this legislation we can begin to remove the barriers that prevent a rehabilitated person from achieving full recovery and citizenship. Without a system response, today's solutions will be tomorrow's problems.

Thank you, Chairman, and Members of the Subcommittee.

[The prepared statement of Ms. Rodriguez follows:]

PREPARED STATEMENT OF PAMELA RODRIGUEZ

TASC IN ILLINOIS

I would like to thank Chairman Coble, Ranking Member Scott and the Subcommittee for inviting me to testify today. I am the Executive Vice President of TASC (Treatment Alternatives for Safe Communities), which is a statewide not-for-profit organization that provides access to recovery and other specialized services for individuals involved in Illinois' criminal justice, corrections, juvenile justice, child welfare and public aid systems. TASC's programs reach over 30,000 people across Illinois each year, including our Corrections Transitional Programs, which provide clinical case management to more than 4,000 adults annually who are reentering the community following incarceration. TASC works with an array of service providers and community partners, including treatment, recovery support, non-traditional providers and faith-based organizations throughout the state.

TASC is challenged every day with helping our clients overcome obstacles that prevent them from accessing the critical services and resources they need to become productive citizens following incarceration. Most of our clients are ill-equipped for lives of stability, health and self-sufficiency. Many have substance use or mental health issues that were in existence before their incarceration. Many need legitimate employment, stable housing and community support to have any hope of a crime-free lifestyle. For most of our clients, successful reintegration requires the careful and deliberate navigation of an array of programs, public systems, communities and the demands and expectations placed on returning offenders.

To address the many barriers faced by our clients, TASC helps parolees complete their justice requirements and successfully reintegrate into their communities. Our programs work to develop collaborative, systems-level responses that balance the supervisory, health, welfare and justice needs of the ex-offender, his or her family and community. By acting as an independent entity, TASC utilizes a clinical case management approach to integrate all of these requirements into a service delivery plan tailored to the unique needs of each individual and is also responsive to the need for accountability, public safety and efficient use of public resources.

A primary goal for TASC's case management model is "restoring citizenship." This entails supporting and guiding former offenders as they learn positive ways of thinking, living and being. TASC transforms lives formerly characterized by involvement with drugs and the criminal justice system by working with individuals to learn the meaning and rewards of genuine self-care and respect for others. TASC clients develop the skills, attitudes and behaviors that are consistent with positive citizenship, including assuming responsibility for self-direction and making positive contributions to their families, workplaces and communities. In the process of restoring citizenship, there is a healing of past harms and reassurance to victims, families and communities that change is possible. To accomplish these goals, TASC also works closely with community members and organizations to help them build their own capacity to support and reintegrate ex-offenders.

THE SECOND CHANCE ACT

TASC is in full support of The Second Chance Act, which will address the current system of barriers to successful reintegration that are faced by men and women following incarceration. This vital legislation will help restore citizenship, promote the accountability and responsibility for self that is fundamental to recovery from addiction, encourage family strength and stability and engage communities in the rehabilitation of their own citizens. TASC has had the honor of working with Illinois Congressman Danny K. Davis on these important issues for many years. As a Cosponsor of this bill, Congressman Davis continues to enhance his lengthy and impressive track record of exceptional dedication and leadership in the areas of reentry and public safety.

The Second Chance Act will provide critical support services that enable ex-offenders to successfully transition back into their communities and stay out of prison and jail, such as substance abuse and mental health interventions and treatment, job assistance and housing. This legislation will promote public safety and save taxpayers dollars by breaking the costly cycle of recidivism that causes individuals, especially those with drug and alcohol issues, to repeatedly offend and serve time in our nation's and state's penal systems.

We know that the problems of alcohol and other drug abuse and mental illness are thoroughly intertwined with crime, incarceration and recidivism. We also know that assessment, intensive clinical case management, intervention and treatment

work to reduce drug and alcohol addiction and treat mental health conditions for those involved in the criminal justice system. Therefore, it makes sense to expand the provision of these vital services in prisons and jails and in aftercare programming if we want to prevent re-offense and re-incarceration. Assessment and case management are essential to bridge the system and community providers, ensuring that individuals are linked with appropriate treatment and meet the requirements of courts and parole. This legislation takes important steps toward expanding these services in our nation's prisons and jails.

We also know that ex-offenders who cannot secure stable housing or steady employment, and whose families have suffered the strain of separation, have a much harder time staying out of prison and jail. This legislation will continue to fund state and local government programs that provide housing, education, job training and family initiatives, all of which contributes toward answering the immediate and pressing needs of returning individuals and their families.

As stakeholders with a vested interest in public safety and the health and well-being of all of its citizens, community providers are in a unique position to affect the successful reentry of its incarcerated population as individuals return from prison and jail. The Second Chance Act engages community non-profits, including faith-based providers, in serving and empowering their own populations in successful reentry through programs such as President Bush's Mentoring Prisoners grant program, which provides funding for adult offender mentoring and reintegration transitional services. I would like to acknowledge President Bush's vision in the area of reentry and thank him for his leadership in bringing attention to this important issue.

This legislation begins the process for ensuring better coordination and planning for release by providing necessary interventions and treatment for alcohol and drug addiction, treatment for mental health disorders, recovery support services, job training, education, housing services and family assistance in preparation for and upon release. TASC strongly urges Congress to support this legislation to improve the health, justice, welfare and safety of all of our residents and communities.

Thank you, Chairman Coble and members of the Subcommittee, for hearing my testimony before you today. I would be happy to answer any questions you may have.

Mr. COBLE. Thank you, Ms. Rodriguez.

Mrs. Hogan.

TESTIMONY OF LORNA HOGAN, ASSOCIATE DIRECTOR OF SACRED AUTHORITY, PARENT ADVOCATE, THE REBECCA PROJECT FOR HUMAN RIGHTS, WASHINGTON, DC

Ms. HOGAN. Good afternoon, Members of the Committee. It is a privilege to be here today.

My name is Lorna Hogan and I'm the mother of four children. At the age of 14, I began abusing marijuana and alcohol as a way of coping with being physically, mentally, and verbally abused. I was afraid to tell anyone what was going on, and self-medicating was the only way I knew that could ease the pain. After awhile, the combination was not working. I needed something stronger to help me cope with the abuse. I began using crack cocaine. Crack cocaine would take me to horrible places I never imagined I would even go. The once-clean police record I had became stained with drug-related charges I committed to support my habit.

My children were definitely affected by my drug use. I wasn't a mother to them. My grandmother was raising them, and when she became ill, I began leaving them with other people. I couldn't stop using. I tried 28-day treatment programs, but I was just detoxing. I was not getting help for the emotional pain I kept suppressed by using drugs. There were no services provided for me as a mother, there were no services for my children. There were no opportunities to heal as a family.

In December of 2000, I was arrested on a drug-related charge and my children were placed with Child Protective Services. When I went before the judge for sentencing, I begged him for treatment. The judge refused my request. I felt hopeless. I not only lost my children, I lost myself. I didn't know where my children were or what was happening to them. I felt I would never see them again.

In jail I received no treatment. I was surrounded by women like myself. We were all mothers. We were all there in jail suffering from untreated addiction. But there were no treatment services in jail for us. When I was released, there were no referrals to aftercare treatment programs. I was released to the street at 10 o'clock at night, with $4 in my pocket, and I still didn't know where my children were. I went back to doing the only thing I knew, which was using drugs. I felt myself sinking back into a life of self-degradation.

Months later, by the grace of God, I finally found someone to listen to me, a child welfare worker who was assigned to my case. She referred me to an 18-month family treatment program. A family treatment program is where a mother can go with her children and the whole family as a unit can receive services. At family treatment, I addressed the underlying issues of why I used. I identified the many ways that I self-medicated my pain. I had a therapist to help me address the guilt and shame of being a mother who used drugs. I had a primary counselor I could talk to at any time.

I also had parenting classes that gave me insight on being a mother. When my children were returned to me during treatment, my children received therapeutic services so that they, too, could heal from the pain of my addiction.

Today I am a graduate of the family treatment program. I acknowledge 5 years clean time from drugs and alcohol. My case with Child Protective Services is closed. My children and I have been reunified for 4 years. We live in our own home in Montgomery County. My children are succeeding academically in school. I am a PTA mom. We are a whole and strong and loving family today.

I would like to conclude my story by sharing with you how critical it is for mothers like me to receive access to family-based treatment. When moms enter into family treatment programs, we have a 60 percent success rate. We stay clean. We don't re-enter the criminal justice system. And we stabilize our families.

Most mothers behind bars are non-violent drug felons, and they are untreated addicts. They receive little or no opportunity to heal from their addiction. The absence of treatment services for mothers is apparent at every point in their involvement with the criminal justice system. Pretrial diversion, release services, court sentence alternatives, and re-entry programs for women offenders are restricted in number, size, and effectiveness. Mothers behind bars and mothers re-entering the community need treatment. We need comprehensive family treatment to break the cycle of addiction in our families and to close the revolving door of the criminal justice system. We need comprehensive family treatment so that we can stabilize our families and raise our children with health and dignity.

If moms behind bars are sentenced to family treatment programs, and if family treatment is made available to mothers re-

turning to the community, so many families will have a real chance to heal and to stabilize. And like my family, they will have the chance to truly recover and not be lost to the criminal justice system.

Thank you.

[The prepared statement of Ms. Hogan follows:]

PREPARED STATEMENT OF LORNA HOGAN

Good afternoon Members of the Committee, it is a privilege to be here today. My name is Lorna Hogan and I am the mother of four children. At the age of fourteen, I began abusing marijuana and alcohol as a way of coping with being physically, mentally, and verbally abused. I was afraid to tell anyone what was going on and self-medicating was the only way I knew that could ease the pain. After awhile, this combination was not working. I needed something stronger to help me cope with the abuse. I began using crack cocaine.

Crack cocaine would take me to horrible places I never imagined I would even go. The once clean police record I had became stained with drug related crimes I committed to support my habit. My children were definitely affected by my drug use. I wasn't a mother to them. My grandmother was raising them and when she became ill, I began leaving them with other people.

I couldn't stop using. I tried 28 day treatment programs but I was just detoxing. I was not getting help for the emotional pain I kept suppressed by using drugs. There were no services provided for me as a mother. There were no services for my children. There were no opportunities to heal as a family.

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sive family treatment so that we can stabilize our families and raise our children with health and dignity.

If moms behind bars are sentenced to family treatment programs, and if family treatment is made available to mothers returning to the community, so many families will have a real chance to heal and to stabilize. Like my family, they will have the chance to truly recover and not be lost to the criminal justice system.

Thank you

ATTACHMENT

FACT SHEET ON MOTHERS BEHIND BARS

THE INCARCERATION OF WOMEN FOR NON-VIOLENT OFFENSES
The rate of women's incarceration for non-violent drug felonies has outpaced the rate of incarceration for men each year since the mid-1980s. While the total number of male prisoners since 1990 grew 77%, the number of female prisoners increased 108%.

Women are more likely to serve sentences for non-violent drug offenses than violent crimes.

MOST WOMEN BEHIND BARS ARE MOTHERS
Two-thirds of incarcerated women have minor children:

In State prison, 65.3% of incarcerated women are mothers to minor children and in Federal prison 58.8% are mothers to minor children.

70% of women in local jails and 72% of women on probation are mothers to minor children.

Approximately, 1.3 million minor children have mothers under supervision by justice system agencies. Over 250,000 of these minors have mothers who are serving time in prison or jail.

Many women enter jail and prison pregnant. In 1997-98, more than 2,200 pregnant women were imprisoned and more than 1,300 babies were born in prisons.

In most states, including the District of Columbia, pregnant women birthing their children at the time of their incarceration must give birth in shackles. In state and federal prisons, children are generally removed from their mothers after delivery.

MOST MOTHERS BEHIND BARS ARE UNTREATED ADDICTS
80% of women in state prisons have substance abuse problems.

Nearly 1 in 3 women serving time in state prisons reported committing the offense to support their addiction.

According to BJS, 89% of incarcerated women reported using drugs on a regular basis at the time of the offense.

Mothers behind bars receive little or no opportunity to access treatment services and programs. The lack of treatment services is apparent at every point in their involvement with the criminal justice system: pre-trial diversion, release services, court-sentenced alternatives and re-entry programs for women offenders are restricted in number, size, and effectiveness.

HARM TO THE CHILDREN
More than half of the children of women prisoners never visit their mothers during the period of incarceration. The lack of visits is due primarily to the remote location of prisons, lack of transportation, and the inability of caregivers to arrange visits.

Separating children from their mothers, especially at birth, inimically interferes with the mother-infant attachment and can result in adverse cognitive and emotional developmental delays.

Children separated from their mothers are more vulnerable to substance abuse, developmental delays, and involvement in the criminal justice system.

Prepared by: The Rebecca Project for Human Rights
February 2006

COMPREHENSIVE FAMILY TREATMENT WORKS

THE NEED FOR FAMILY TREATMENT PROGRAMS

Mothers with substance abuse issues are generally victims of sexual and domestic violence. Often, the underlying reasons for addiction among mothers are untreated post-traumatic stress and/or major depression disorders, precipitated by the injuries of sexual and domestic violence.

When these mothers seek out treatment to heal from their addiction, they face an uphill battle. Families struggling with substance abuse issues are offered few opportunities to find treatment and recovery for themselves and their families:

- The 1996 Uniform Facility Data Set found that only 6 percent of the treatment programs surveyed included prenatal care and 11.5 percent provided childcare.

Parents involved in the child welfare system are especially impacted by the dearth of drug treatment programs available to families:

- Between one-third to two-thirds of parents involved in the child welfare system require substance abuse treatment, yet existing treatment meets less than one third of that need.
- Alcohol and drug-related cases are more likely to result in foster care than are other child welfare cases.
- Only ten percent of child welfare agencies report that they can successfully find substance abuse programs for mothers and their children who require the treatment in a timely manner.

FAMILY TREATMENT OUTCOMES

Although family-based treatment represents a small percentage of the overall treatment available, family treatment programs enjoy consistently high levels of success.

In 2001, the Center for Substance Abuse Treatment (CSAT) evaluated its Pregnant and Postpartum Women and Their Infants Program, which provides comprehensive, family-based treatment for substance abusing mothers and their children. Major findings of this study, at 6 months post treatment, include:

- 60% of the mothers remained alcohol and drug-free.
- Drug-related offenses declined from 28% to 7%.
- 38% obtained employment and 21% enrolled in educational/vocational training.
- 75% of the mothers had physical custody of one or more children.

In 2003, an additional cross-site evaluation of 24 residential family-based treatment programs 6 months after post-treatment revealed successful outcomes for mothers and their children:

- 60% of the mothers remained completely clean and sober 6 months after discharge.
- Criminal arrests declined by 43%.
- 44% of the children were returned to their mothers from foster care.
- 88% of the children treated in the programs with their mothers remained stabilized and living with their mothers, 6 months after discharge.
- Employment rose from 7% before treatment to 37% post-treatment.
- Enrollment in educational and vocational training increased from 2% prior to treatment to 19% post-treatment.

Mr. COBLE. Thank you, Ms. Hogan, and thanks to all of you.

Now, for the benefit of the witnesses, we impose the 5-minute rule against us as well. So if you could keep your questions as terse as possible.

Dr. Volkow, what are the implications for the criminal justice system based on NIDA's research showing that drug addiction disrupts the brain circuits in processing of reward and punishment factors.

Dr. VOLKOW. The circuits involved in punishment and reward are circuits that are in our brain in order to motivate behaviors that are indispensable for survival, such as finding food, finding a partner, taking care of children. And drugs activate exactly the same circuits, but in much more efficient ways. When a person becomes addicted, those circuits basically signal to the brain the equivalent of a signal "you need to do the drug in order to survive." So the person that is addicted in that process seeks the drug not out of pleasure, but out of need.

Mr. COBLE. And knowing, I guess, that punishment may be forthcoming.

Dr. VOLKOW. Knowing that punishment may be forthcoming, but the value of punishment, when the signal is one of survival, becomes pale in comparison. So the person seeks the drug regardless of the catastrophic consequences. And that, I think, is a message extraordinarily important for the criminal justice system, because one of the things that is very frustrating in speaking with judges is how come we cannot affect the behavior by punishment? Well, the brain is not responding the same way that it would had that person not been affected by the drugs.

Mr. COBLE. I got you. Thank you.

Ms. Hogan, for my information and the information of the Subcommittee, when you were confined and there was no treatment available, was that in a State-operated institution or county, or Federal?

Ms. HOGAN. It was a county.

Mr. COBLE. A county jail?

Ms. HOGAN. A county jail.

Mr. COBLE. And when you asked for treatment, you said the judge just turned a deaf ear to you?

Ms. HOGAN. He just basically told me he heard it before and the same people keep coming before him over and over again.

Mr. COBLE. Well, your story, Ms. Hogan, is an inspiration, I think, for all of us and reminds us of the real benefits that a comprehensive re-entry program can have, as each of you has explained.

Now, answer this for me, Ms. Hogan.

Ms. HOGAN. Yes?

Mr. COBLE. How important do you see family-based therapies for drug addiction?

Ms. HOGAN. It's very important, because there are so many underlying issues of why a person used in the first place. And with comprehensive family treatment, not only is that parent getting the help, the children also need therapy.

Mr. COBLE. I guess it is what did it for you?

Ms. HOGAN. Yes, it did. Yes, it did.

Mr. COBLE. And you came out very well. I commend you for that.

Ms. HOGAN. Thank you.

Mr. COBLE. Mr. Batten, when authorizing new Federal drug treatment and re-entry programs, why is it so important to coordinate—Well, strike that.

Is it important—I think it is—to coordinate with a Single State Authority for Substance Abuse? Do you concur with that?

Mr. BATTEN. Yes, Mr. Chairman, I do concur with that. In Virginia we have over the years coordinated with our counterparts in the criminal justice system on a number of occasions. When we don't coordinate well, we end up duplicating each other's efforts, or actions that we should be taking get lost. When we coordinate, we sit down at the table, we discuss how to ensure that people receive continuing care upon release, how to begin developing services inside the prisons and the jails, and ensuring that continuing care takes place upon release. While we would like to do more, we are limited in terms of the resources that we have available.

Mr. COBLE. I see.

I think I have time for one more question. Ms. Rodriguez, what role does TASC play in providing integrated services to an offender, A, and what types of services are included?

Ms. RODRIGUEZ. TASC serves an independent case management function advocating for the individual, bridging the criminal justice system with community treatment. And the community treatment involves substance abuse treatment, mental health treatment, housing, employment, all of the kinds of supportive services we're talking about in second chances.

Mr. COBLE. I thank you. And I see my light's about to come on.

Mr. Scott from Virginia.

Mr. SCOTT. Thank you, Mr. Chairman.

Dr. Volkow, when you talk about comprehensive services, what are you talking about?

Dr. VOLKOW. What I meant by that is that, first, you have to evaluate the unique needs of that substance abuser. Because if you don't, what's going to happen is exactly like it was described here: you are sending a prisoner that abuses substances out on the street with no resources. So you have to evaluate that the family structure is properly taken care of, that the individual is evaluated for the presence of mental disorders. Comorbidity in the substance abusers in the criminal justice system is more the rule than the exception. If you don't treat depression in a substance abuser, the likelihood of succeeding in keeping that person out of drugs and reincarceration is very, very low.

You have to address issues of medical health. Unfortunately, the rate of infection of substance abusers and individuals that are in the criminal justice system is significantly higher than that of other individuals. As a result of that, it becomes urgent, it becomes a need to not only evaluate but to educate that person about proper behaviors.

And finally, you need to provide a mechanism by which that person can succeed—if it's an adult, through their job; if it's a young person, through education; and if it's a mother, through providing them the skills to properly train their children.

That's what I mean by "comprehensive." You cannot just look at one aspect and forget the rest. You will fail.

Mr. SCOTT. Is there any question that comprehensive services will actually reduce drug use?

Dr. VOLKOW. There is consistently data showing that comprehensive services reduce the rate of substance abuse. And in fact, to me, one of the real success stories in the criminal justice system is the drug courts. It is very visionary. And the basis of the drug courts is that sense that you need to address the multiple aspects of an individual's life that have been disrupted by drug abuse. And the reason why they have been so successful in so many instances is that they have been able to do that very properly.

So, yes, if you just aim and say, okay, you have a drug addiction but I won't care about your family, I won't care about your mental disease or that you don't have a job, I just care that you have a drug problem—you will not be able to keep that person off of drugs.

Mr. SCOTT. But if you do the comprehensive services, you will reduce drug——

Dr. VOLKOW. Significantly. And I just put that story. I mean, in medicine it's rare to have such a successful story. You are bringing the rate of drug use sevenfold lower. I mean, it's not half, it's sevenfold lower. Reincarceration to half.

Mr. SCOTT. Now, Mr. Batten, you indicated that it's important to coordinate the services. Could you give us an example of different agencies involved in this coordination?

Mr. BATTEN. Well, one of the examples that Dr. Volkow mentioned is critical; for example, drug courts. The reason drug courts are so effective is that they coordinate the efforts of the judiciary, probation and parole, the treatment agencies, and all other organizations that are involved with that particular individual. What they do is they engage the individual and keep them involved in this process over an extended period of time, which today continues to be the single biggest predictor of success.

When we do that on a State level with respect to coordinating our efforts, as we have done in the past with an initiative in Virginia called SABER, we were able to bring together and sit at the table the State's Attorney General, the Department of Corrections, Department of Juvenile Justice, our own agency, the Department of Mental Health, Mental Retardation & Substance Abuse Services, and design a program that led to the screening and assessment of all individuals that presented with substance abuse issues, got them engaged in treatment and referred to appropriate services.

So there are numerous examples where we have been able to do this. It has to do with ensuring that the proper people are at the table to sit down to plan the services and then to be able to implement those services.

Mr. SCOTT. Now, I assume that it is important to have professional qualifications to provide these services. Is that right?

Mr. BATTEN. There's a place for everybody at the table, Mr. Scott. It is important to have people with professional credentials at the table, but it's also appropriate to have people from the faith-based community at the table, individuals from the recovering community at the table. Everybody needs to be at the table in a coordinated

way. The professional treatment services provide important services, but when we all work together, it works very well.

Mr. SCOTT. Should you lower professional credentials to—is there anything good about reducing professional credentials in coordinating the services, or are professional credentials important?

Mr. BATTEN. I think professional credentialed individuals are important for the level of care that needs to be provided to individuals who have complex needs. As Dr. Volkow had indicated, when you have an individual who has co-occurring problems, you have to have individuals who understand the interplay of the substance use disorder and the mental health disorder at the same time. And if you lower credentials for particular kinds of cases, you run the risk of not addressing the core issues with that particular individual.

Mr. SCOTT. Is there any reason to backtrack on anti-discrimination provisions in employment?

Mr. BATTEN. I'm not sure——

Mr. SCOTT. If we were to fund programs, is there any justification for allowing Federal grantees to discriminate in employment?

Mr. BATTEN. I think, again, it would——

Mr. SCOTT. Is the ability to discriminate based on race or religion an important initiative from the National Association of State Alcohol and Drug Abuse Directors?

Mr. BATTEN. I don't think that—I'm not familiar with that position on the part of the National Association of State Alcohol and Drug Abuse Directors.

Mr. SCOTT. They're not suggesting to us that we ought to allow Federal grantees to go around discriminating based on race or religion?

Mr. BATTEN. Not to my knowledge.

Mr. SCOTT. I just have one other question, if I could. And, Mr. Batten, you indicated in your written testimony $1 spent on treatment yields $7 on future savings. Can you or somebody else give us an idea of where we would save money if we actually reduce the use of drug abuse?

Mr. BATTEN. Well, I'm sure others can chime in with that, but failures revolve through our systems over and over and over again when, if you just delayed the revolving door, to a certain extent you would save a significant amount of money, because a lot of the money associated with individuals in our system is the time that they spent in jail, the time that they spent in emergency rooms, the time they spent impacting all of our social services. If you can intervene with the individual and reduce recidivism and reduce that revolving door, then those are cases that don't consume those resources. That's part of where that $7 comes from.

Another part of where that $7 comes from is that those individuals, in the course of their treatment, are going to be reentering society, they're going to be working, they're going to be paying child support, they're going to be doing a variety of things. So I think the $7 figure is conservative. But that's where our savings are, just simple intervention. If we could, for example, reduce the number of individuals going into our prisons in Virginia by 1,300 cases a year—and you've heard testimony here today about the number of inmates who have these problems—we could save the cost of a sin-

gle prison. And the cost of a single prison, as you are aware, is astronomical. So the potential savings in this area are extraordinarily significant.

Mr. SCOTT. Does anyone else want to comment?

Dr. VOLKOW. I want to just make a comment because I think this is very important when we're dealing with issues of cost effectiveness. There's something that's very difficult to quantify—which is exactly exemplified by the witness, that notion of the disruption that it creates to a family to have one of the parents incarcerated. Not only incarcerated, but not even addressing the issue of substance abuse. The cost to those children, for example, in special education, the cost to them in terms of emotional suffering—how do you quantify that?

And also, if you are a juvenile offender, the cost of that juvenile offender vis-a-vis not having the ability to educate themselves at that stage in life, where you're actually building up for the future is basically almost in many cases irreversible.

So, I mean, it goes beyond putting a dollar amount into these things.

Mr. COBLE. Ms. Hogan, do you——

Ms. HOGAN. I just wanted to add that the cost to keep—if I had not gotten comprehensive family-based treatment, the cost for me to be incarcerated would be about $35,000 a year.

Mr. COBLE. Ms. Hogan, I was going to ask you, are your children with you today?

Ms. HOGAN. Oh, yes, they are.

Mr. COBLE. I'd like to——

Ms. HOGAN. Oh, not today. No, unfortunately they are home from school. [Laughter.]

Mr. COBLE. Well, folks, Mr. Scott and I and counsel appreciate what you all have done. Let me just conclude with this comment. And this is what frustrates me about—I have many frustrations about addiction, but one of the most prominent ones is the fact that it seems to know no respect for anyone. It cuts across racial lines—black, white, red, yellow; it cuts across social lines—impoverished, wealthy. I've known poor people who are unemployed who became addicted; conversely, I've known well-educated people, Mr. Scott, fully employed, independently wealthy: addicted. And that makes it an even more difficult target, I think, to nail.

But I thank you all for your testimony. We very much appreciate your attendance today. In order to ensure a full record of adequate consideration of this important issue, the record will be left open for additional submissions for 7 days. So any written questions that a Member may want to submit to you all, or conversely, if you all want to submit additional information to us, please do so within the 7-day time frame.

The concludes the legislative hearing on H.R. 1704, the "Second Chance Act of 2005" (Part II): An Examination of Drug Treatment Programs Needed to Ensure Successful Re-entry.

Thank you all again, not only for the witnesses, but for those in the audience, for your attendance as well. And the Subcommittee stands adjourned.

[Whereupon, at 4:52 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF THE HONORABLE ROBERT C. SCOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING MEMBER, SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

Thank you, Mr. Chairman. I want to thank you for your dedication to developing an effective prisoner reentry system in this country and for the bi-partisan, open-minded approach you and your staff have taken in doing so. I also want to thank you for holding this second hearing this Congress on prisoner reentry issues, and in particular for this hearing emphasizing the importance of drug treatment in assuring that released offenders remain crime free and live productive lives. I fully expect that we will hear today what has been clear for some time now—that drug treatment for returning offenders greatly reduces recidivism and saves more money than it costs in avoided law enforcement and incarceration expenditures.

While assisting returning offenders is a cost-effective reason to develop and expand effective prisoner reentry programs, I know that you are as aware as I am, Mr. Chairman, that the most important reason for doing so is because it better assures that members of the public will not be victims of crime due to recidivism.

This year, close to 700,000 people will leave prison in the U.S. Most of them are ill-prepared to succeed in earning a living and leading a law-abiding life, and the resources available to assist them re-enter successfully are very limited. The addition of a felony record and a prison stay certainly does not assist their job or social development prospects. So, with no or limited education, resources, job skills, federal benefits disqualifications due to drug or other convictions, and often no family or community support, not surprisingly, as many as two-thirds of released prisoners are rearrested for new crimes within 3 years of their release.

Although the national crime rate has fallen significantly over the last decade, we are seeing a continuing and unprecedented increase in our prison and jail populations. All of this focus on increasing sentences has led us to the point that we now have, on a daily basis, over 2.2 million people locked up in our nation's prisons and jails, a 5 fold increase over the past 20 years.

As a result of this focus on incarceration, the U.S. is the world's leading incarcerator, by far, with an incarceration rate of 726 inmates per 100,000 population in 2004. The closest competitor is Russia with 532 inmates per 100,000 population. The U.S. rate is almost 7 times that of the industrialized nations to which we are most similar—Canada and western Europe. The rate per 100,000 population is 142 in England/Wales, 117 in Australia, 116 in Canada, 91 in Germany, and 85 in France.

Despite all of our tough sentencing for crimes, over 95% of inmates will be released at some point. The question is whether they re-enter society in a context that better prepares them and assists them in leading law-abiding lives, or continue the cycle of ⅔ returning in 3 years? So, if we are going to continue to send more and more people to prison with longer and longer sentences, we should do as much as we reasonably can to assure that when they do return they don't go back to prison due to new crimes.

Mr. Chairman, as I expect we will see from the testimony today, we have the experience, the evidence and the experts to show that we can reduce recidivism through smart reentry programming. What's needed are the authorizations and the resources to carry out the programming. The Second Chance Act, H.R. 1704, of which you and I both are cosponsors, is a bi-partisan bill supported by a broad-based coalition of organizations and individuals, liberal and conservative, who recognize the importance of our moving forward on this issue. I believe this hearing provides important part of the foundation for our taking the next step toward passing a well-founded, effective reentry bill. I look forward to the testimony of our wit-

nesses today, Mr. Chairman, and to working with you to pass the Second Chance Act into law. Thank you.

PREPARED STATEMENT OF SCOTT A. SYLAK, EXECUTIVE DIRECTOR, LUCAS COUNTY TASC, INC.

INTRODUCTION

Chairman Coble, Ranking Member Scott, Members of the Subcommittee, I am Scott Sylak and I serve as the Executive Director of Lucas County TASC, Inc. in Toledo, Ohio. I am also the President of National TASC (Treatment Accountability for Safer Communities). National TASC is a nonprofit association representing individual and agency programs across the United States. National TASC and its members aim to improve the professional delivery of screening, assessment and case management services to justice-involved persons with substance abuse or behavioral health problems.

Thank you for holding hearings regarding offender reentry and substance abuse treatment and the need to assure that offenders make a successful reentry when released from prison or jail. National TASC appreciates this focus on securing substance abuse treatment, especially because an estimated 80% of the state prison population report histories of substance abuse, 90% fail to obtain those services while incarcerated. It is estimated that only 10% of offenders receive appropriate community linkage and follow-up services upon release. We can do more to use proven and effective techniques that have been employed by TASC programs in many jurisdictions to reduce the number of unmanaged reentry cases in need of services and to improve the outlook for a substantial number of offenders who reenter society in need of substance abuse services.

National TASC supports the Second Chance Act as critically important legislation that can address multiple challenges related to the return of incarcerated persons from prisons to their communities. A majority of those returning are young, lack a job, have two or more minor children and have a lower educational attainment and housing stability history than those who have never been incarcerated. More than two out of three returning from prison have a substance abuse or mental health history that will require treatment and support. Many also need medications to treat HIV and other communicable diseases. A growing number of released offenders do not have housing and become homeless after discharge from criminal justice custody. Without case management and appropriate services, this population will continue to drive up costs to our communities. Combining targeted clinical case management with services and resources that prevent new crime can solve many of these problems.

NATIONAL TASC'S RECOMMENDATIONS

1. Develop a comprehensive approach that ensures coordination of funds and services at the state level.

In many states TASC programs already exist that can serve as a flexible approach to management and integration of offender services, the criminal justice system and other systems (justice, health, education, housing, employment, family services and community-based networks). TASC elements have been incorporated in many local pretrial, probation, parole, community corrections and substance abuse programs as well as drug courts, juvenile and family services interventions.

TASC supports the Second Chance Act's design to encourage reentry partnerships among many federal, state and local agencies. TASC also knows that this process does not necessarily create the need for a large, costly bureaucracy. For substance abusing offenders, a central focus will be the development of capable professionals who serve released persons and their families as well as working with faith, community and mentoring programs. Bridging entities such as TASC build working partnerships between groups and organizations that serve individuals in the justice system. Examples of this can already be seen in the Breaking the Cycle Program in Birmingham, Alabama as well as throughout the state of Ohio.

2. Prevent recidivism by addressing known barriers to offender reentry such as substance abuse.

States can provide new ways to build effective services using the core components of cost-effective TASC programs as models. This will encourage development of stronger clinical reentry case management in communities already engaged in this effort. In many areas TASC programs provide communities with independent assessment, clinical case management and system integration techniques designed to

intervene in the lives of offenders with addictions or behavioral health needs. TASC-style case management provides coordinated individual assessments, appropriate service delivery and resources targeted to follow offenders in need from prison to their home communities. This form of case management helps ensure that offenders who are released from jail and prison have the resources and supervision necessary to become productive members of their communities.

3. Encourage reentering persons to access appropriate opportunities for post-incarceration services.

This bill provides opportunities for states and localities to develop clinical responses across a variety of systems to provide incentives for more effective offender release procedures. It encourages application of the best practices from corrections and parole to substance abuse treatment and clinical case management. Experience with the TASC clinical case management model indicates that the complex systems of housing, employment, substance abuse, mental health and child welfare must be integrated into offender reentry management. The Second Chance Act allows each of these systems to serve their primary functions while building their services, furthering the goals of community safety, offender reentry and client rehabilitation. It also encourages these sectors to understand the need for offender accountability to the court and to the community while maintaining focus on the clinical needs of the individual.

4. Prioritize the use of scarce criminal justice resources to provide drug treatment access to those most vulnerable to relapse.

TASC programs operate within the parameters of the larger justice and treatment systems. For over thirty years TASC programs have served as a catalyst to develop more effective strategies for delivering services to persons involved in the justice system and their families. Although TASC programs have served to educate communities about their clients, local and state executive agencies are often responsible for funding, oversight and management of offender services, treatment and resources. Consequently there is a complex political and cultural climate in many communities that makes it difficult to achieve adequate client services for reentering offenders. By using independent case management, funded programs will help overcome inadequate or inconsistent services. This process can ensure that those who need treatment the most are the most likely to receive it.

5. Manage substance abuse, mental health, housing, medical, employment and family needs.

By providing for clinical reentry case management, reentry agency partners and TASC agencies can accomplish the following:

- Screen and assess for housing needs and develop a short- and long-term plan for residential housing to make sure that released offenders to not become homeless.
- Evaluate the complex problems and diagnoses related to substance abuse and mental health disorders in individuals and their families and refer clients to appropriate treatment, ensuring that the system finds the problems before offenders recidivate.
- Assess employment readiness, job placement needs and refer to workforce development specialists or education programs that are more tailored to individual strengths, improving the likelihood of employment.
- Follow-up progress with case management that provides incremental steps in the domains of housing, treatment, employment and family stability.
- Monitor and report progress to ensure compliance with expectations of the justice system. Routine reporting will prompt sanctions if offenders fail to make progress.
- Advocate and provide linkages to the community to further help offenders make the transition back into society.

6. Build elements into every funded program that measure accountability data and improve outcomes.

In order to absorb the impact of more than 600,000 reentering persons each year, communities must develop and coordinate effective transitional partnerships that assist individuals in meeting justice system requirements while successfully negotiating the necessary transition to communities, families and employment. This includes the following critical elements.

- A process to coordinate justice, treatment and other systems.

- Procedures for providing information and cross training to justice, treatment and other systems.
- A broad base of support from the justice system with a formal structure for effective communication.
- A broad base of support from the treatment and other social service communities.
- Assessment and case management independent from justice and treatment.
- Policies and procedures for regular staff training.
- A management information system with a program evaluation design.
- Clearly defined client eligibility criteria.
- Screening procedures for identification of candidates within the justice system.
- Documented procedures for assessment and referral.
- Policies, procedures and protocols for monitoring TASC clients' alcohol and drug use through chemical testing.

The development of these systems between government and private and local agencies is one of the most difficult aspects of reentry management. Despite this challenge, there is evidence that a wider application of proven justice system innovations can result in more positive outcomes for this population.

CONCLUSION

On behalf of National TASC, I wish to thank the Subcommittee for holding a hearing on substance abuse systems and their role in offender reentry. Thank you for allowing my participation.

PREPARED STATEMENT OF WILLIAM F. NELSON, DIRECTOR OF CORRECTIONAL SERVICES, VOLUNTEERS OF AMERICA

Chairman Coble, Ranking Member Scott, and Members of the Committee, I want to commend you for focusing today's hearing on the importance of drug treatment to the successful and safe reentry of ex-offenders into our communities and neighborhoods. The Second Chance Act (HR 1704) will be an important tool that will help entire neighborhoods, in partnership with law enforcement agencies and social services delivery systems, to find community solution alternatives to criminal activity associated with drug dependency.

My name is Bill Nelson and I am the Director of Correctional Services for Volunteers of America- Minnesota. For the past 32 years, I have served as the director of a federal pre-release center (halfway house), a privately operated jail for women serving Ramsey county (St. Paul), and a residential treatment center for women leaving the lifestyle of prostitution. I am pleased to share with the Subcommittee information about the *Women's Recovery Center* ("WRC"). The WRC offers participants chemical dependency treatment and sexual trauma therapy, assistance in restoring family ties and developing living skills and competencies to support them in leaving a life of prostitution. Operating for the past six years, the WRC has an 85% rate of success in achieving sobriety and leaving the lifestyle of prostitution. The uniqueness of this program and its treatment approach has attracted worldwide and national attention from a variety of levels of government.

Many studies point to the fact that a very large percentage of offenders commit crimes while under the influence of alcohol or drugs. They are punished often through commitment to prison, fulfill the terms of their sentence, and are released without any significant attention paid to their chemical dependency. While it may be said that chemical dependency does not directly cause crime, there is a significantly high association between drugs and crime. Further, professionals in the criminal justice system observe that repetitive crime coincides with continued use of chemicals.

PROSTITUTION—A CASE IN POINT

Prostitution is both a complex and costly crime. Though offenders typically are charged at a misdemeanor level, the cost to society is enormous. In one benchmark study on criminal justice costs for prostitution, The Sentencing Project in Washington DC estimated that in Chicago, the total cost for each prostitution arrest was $1,554 in 2001, for a system total of $9,089,252. While most prostitution activities are addressed on the local level, the related drug activity frequently serves as a feeder for prison commitments based on related crimes, including sales and distribu-

tion. Although some offenders go to prison, many do not and are absorbed in the local criminal justice network through repetitive jail time.

Since 1984 Volunteers of America - Minnesota has managed a jail/workhouse for women who are committed for periods of up to one year. This private institution serves Ramsey County (St. Paul). In 1998 the jail administration conducted an informal study of inmates who had been repetitively committed for engaging in prostitution. In every case they were committed for drug possession, sales, or related, and were themselves drug users. Based on the study it became obvious that drugs and prostitution were co-occurring phenomena. The number of commitments ranged from 4 to 14 among 12 inmates in the study. The cost implications were startling. Each inmate had cumulatively served 4-6 years of jail time through repetitive commitments. At an average per diem jail cost of $55, this represented a cumulative cost of $80,000 - $120,000 per person with a likelihood of additional costs in the future. Each inmate admitted to being drug addicted.

A PROMISING SOLUTION

Following the study, Volunteers of America - Minnesota proposed a new approach, which emphasized specialized chemical dependency treatment and presented the idea to the 1999 session of the Minnesota legislature. Funding was approved for a pilot program identified as a prostitution recovery center and the program was launched in the year 2000. The application of the "treatment" followed a blueprint of new thinking on gender specific chemical dependency treatment for women identified as the "relational model".

The focus of the residential treatment center is chemical dependency treatment and currently serves 24 clients at a time. All clients have very substantial criminal justice background, are homeless, and most typically, drug addicted and have a long history with multiple incarcerations.

The mission of the Center was established as follows:

To provide therapeutic and life enhancing services that assist women in achieving improved physical, spiritual, mental health, sobriety, and independent living skills and a life without prostitution.

In establishing this mission it is noteworthy that "a life without prostitution" was identified as an outcome and not a goal. Chemical dependency treatment along with the other elements of the program was the focus. Once these issues were to be addressed, it was hypothesized that the criminal justice side of the issue would be effectively addressed, as a consequence.

RESULTS

In 2005 a follow-up study was conducted on 165 women who had been discharged from the program and back in the community for at least one year. Criminal justice data was obtained from the Minnesota Department of Public Safety, Bureau of Criminal Apprehension to determine whether the individuals had any further criminal justice involvement. Using this public information it was determined that 85% had no further criminal justice involvement.

CONCLUSION

Over the years crime has increased exponentially. Associated with this is the geometric rise in costs concomitant with all levels of criminal justice response. It has been said that we cannot "build" our way out of the problem by building additional prison space. Once this space is built and utilized it is likely that it becomes a permanent fixture in state and federal budgets. Fundamental crime prevention can be more effective by applying proven techniques such as chemical dependency treatment as part of an alternative to incarceration or as a post incarceration strategy to prevent further recidivism.

Again, I commend the Subcommittee for its work today in shining a spotlight on the critical importance of drug treatment interventions in putting an end to the "revolving door" of incarceration. At Volunteers of America- Minnesota, we would like to be continuing resource to this Subcommittee in any way we can to further support for, and enactment, of the Second Chance Act.

ADDENDUM TO THE TESTIMONY OF PAMELA RODRIGUEZ, EXECUTIVE VICE PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC), INC.

Addendum to Testimony Provided on February 8, 2006
House Judiciary Committee:
Subcommittee on Crime, Terrorism and Homeland Security

Chairman Coble, Mr. Scott and Subcommittee, in response to your question regarding what TASC does, please allow me to explicate.

TASC gets people into treatment and other services and keeps them there long enough to stabilize in their recovery. ***How do we do that?***

TASC IDENTIFIES people in courts, prisons and jails who are substance abusers needing treatment.

We then ADVOCATE necessary substance abuse treatment on their behalf during interactions with judges, probation officers, parole and prison officials.

When the appropriate authority consents, we MATCH them to the appropriate type of treatment and the right level of intensity and care, with special consideration of need for specialty services like those that are gender-based, culturally and linguistically appropriate, family-oriented, etc. We also match them to the other supportive services and programs including those focused on housing, faith, education, employment, etc., when the time is right.

TASC then PLACES them in treatment, negotiating access to limited services, and helps them navigate the complicated eligibility, admission and financing requirements. We arrange placements based on client needs, their stage in recovery and their readiness for employment, etc.

Once in services, we help RETAIN people in treatment and services. This involves resolving barriers to participation such as transportation, childcare and housing. It means maintaining motivation in clients who are ambivalent about recovery. It also involves facilitating transitions to other levels of care, other programs and other services, changes that represent highly vulnerable points in recovery for many people. Additionally, we work to ensure that providers do not discharge clients prematurely.

Simultaneous to these client services, we MONITOR and REPORT on client progress and keep the court, probation or parole informed about progress, issues and concerns. If necessary, we modify service plans and implement graduated sanctions, in partnership with parole or supervising authorities. We ensure ongoing COMMUNICATION between all parties.

Why are these services necessary? Clients are often ambivalent about recovery – and we know that coercion works. Courts and corrections are not often comfortable balancing public safety risks with recovery. Treatment and service systems are complex, difficult to access and frequently discharge clients for little reason. Clients and

court/corrections and treatment systems have conflicting goals, unique language and inherent mistrust of each other. Collaboration, communication and understanding are uncommon. **TASC works to bridge clients systems, services, goals, ensuring recovery accountability and public safety.**

cc: *Dr. Nora Volkow,* Director, National Institute on Drug Abuse

Jessica Nickel, Director of Government Affairs, Criminal Justice Programs, Council of State Governments

Sue Thau, National Policy Consultant, Treatment Alternatives for Safe Communities

Mary Shilton, Executive Director, Treatment Accountability for Safer Communities

TASC BRIEF OVERVIEW: STUDIES ON EFFECTIVENESS OF CASE MANAGEMENT, SUBMITTED BY PAMELA RODRIGUEZ, EXECUTIVE VICE PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC), INC.

TASC | BRIEF OVERVIEW

Studies on Effectiveness of Case Management

Research has shown that case management improves the appropriateness and efficiency of addiction treatment.

Philadelphia Targeted Capacity Expansion Study

A study conducted at the Treatment Research Institute in Philadelphia concluded that case management is an effective tool to use in increasing the appropriateness of and adherence to quality alcohol or drug treatment in public systems. Researchers found that case-managed MDO (multiple detox-only) patients had a lower proportion of detox-only episodes and higher proportion of detox-plus-rehab episodes.

Treatment Utilization Pattern in 100 Case-Managed MDO (Multiple Detoxification-Only) Patients Compared With All Other Patients Admitted in That Year

	Year 3 (1999–2000)		Year 4 (2000–2001)	
	Case Management Patients	All Other	Case Management Patients	All Other
Number of patients	325	6765	305	6491
Detox only	43%*	48%	39%**	46%
Detox + rehab	15%*	10%	17%**	10%

* = p<.05
** = p<.01
Comparisons are with the corresponding "all other" group. Case management services began in Year 3 of the study.

Source: McLellan, T.; Weinstein, R. L.; Shen, Q.; Kendig, B. A.; Levine, M. (2005). "Improving Continuity of Care in a Public Addiction Treatment System With Clinical Case Management." *The American Journal on Addictions*, 14:426–440, 2005. American Academy of Addiction Psychiatry.

TASC BRIEF OVERVIEW: STUDIES ON EFFECTIVENESS OF TREATMENT, SUBMITTED BY PAMELA RODRIGUEZ, EXECUTIVE VICE PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC), INC.

TASC | BRIEF OVERVIEW

Studies on Effectiveness of Treatment

National Treatment Improvement Evaluation Study (NTIES)

The National Treatment Improvement Evaluation Study (NTIES) is a Congressionally-mandated five-year study of the impact of drug and alcohol treatment on thousands of clients in hundreds of treatment units that received public support from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). The CSAT-commissioned study was conducted by the National Opinion Research Center, University of Chicago, in conjunction with Research Triangle Institute. The information was gathered from 4,411 clients from across the country from 1992-1997. Client-level data were obtained at treatment intake, at treatment exit, and 12 months after treatment exit.

One year following treatment, clients reported increases in employment and income, decreases in homelessness, improvements in mental and physical health, decreases in criminal activity, and decreases in behaviors that put them at risk for HIV/AIDS.

Employment, Income and Housing

- One year following treatment, the rate of employment increased from 51% to 60%.
- The percentage of clients who reported receiving welfare decreased from 40% to 35%.
- Those who reported being homeless at some point during the year fell from 19% to 11% .

Mental and Physical Health

- One year following treatment, alcohol/drug-related medical visits declined 53%.
- Clients who reported inpatient mental health visits decreased by 28%.

Criminal Activity

- One year following treatment, there was a 64% reduction in arrests for any crime.
- The number of respondents who reported selling drugs declined by 78% and shoplifting declined by almost 82%.
- The percentage of clients who largely supported themselves through illegal activity dropped by nearly half—decreasing more than 48%.

High-risk Sexual Behaviors

- One year following treatment, the percentage of persons who had sex for money or drugs dropped by 56%, and the number of people who had sex with an injection drug user was reduced by 51%.
- Those who reported having heterosexual sex with more than one partner and not always using a condom decreased by 35%; those who reported homosexual sex with more than one partner and who did not always use a condom declined by 57%.

Drug Use

- One year following treatment, the number of participants using any drug or a combination of crack, cocaine and/or heroin dropped by as much as 50% among those who had spent at least three months in treatment.

- Clients' use of their primary drug (which led them into treatment), declined from 73% to 38% one year after treatment.
- Cocaine use decreased one year after treatment (from 40% before treatment to 18% after treatment), heroin use was reduced by almost half (from 24% to 13%), and use of crack significantly decreased between the 12 months before and the 12 months after treatment (from 50% to 25%).

Source: Center for Substance Abuse Treatment . (1997). *The National Treatment Improvement Evaluation Study.* Publication #F027. Retrieved January 27, 2005 from http://ncadi.samhsa.gov/govstudy/f027/

Drug Abuse Treatment Outcome Study (DATOS)

The Drug Abuse Treatment Outcome Study (DATOS) represents data gathered between 1991 and 1993. Data were gathered from 10,000 adult clients entering drug abuse treatment programs in eleven representative U.S. cities. Data reflect treatment progress collected at three and six months, and follow-up data collected at twelve months post-treatment.

Results demonstrate drastic reductions in drug use at 12 months post-treatment.

- Regular cocaine use dropped from 66% in the year before treatment to 22% in the year after treatment among those in long-term residential treatment.
- The same downward trends occurred in outpatient, short-term inpatient, and methadone maintenance treatment programs (Hubbard, Craddock, Flynn, Anderson and Etheridge 1997).
- Most importantly, the large decreases in cocaine use in the first year after treatment were sustained over a five-year follow-up period (Simpson, Joe and Broome 2002).

Sources:
Hubbard, R.L., S.G. Craddock, P.M. Flynn, J. Anderson, R.M. Etheridge. (1997). *Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS).* Psychology of Addictive Behaviors. 11(4): 261-278. See charts retrieved January, 27, 2005, from http://www.datos.org 2002.

Simpson, D.D., G.W. Joe, K.M. Broome. (2002). *A national 5-year follow-up of treatment outcomes for cocaine dependence.* Archives of General Psychiatry. 59:538-544. See summary retrieved January 27, 2005, from http://www.datos.org/adults/adults-5yrout.html.

Illinois Statewide Treatment Outcomes Project (ISTOP)

The state-funded Illinois Statewide Treatment Outcomes Project (ISTOP) evaluated almost 2,000 clients in residential rehabilitation, intensive outpatient, outpatient, and methadone maintenance treatment programs from 1998 to 2000. The research consisted of baseline interviews and six-month post-treatment telephone interviews.

Decreased Substance Intake After Treatment

Drug and alcohol use decreased markedly from before the initiation of treatment to six months after treatment completion:

- The percentage of those who had used alcohol in the month before the interview decreased after treatment from 59% to 30%; marijuana use decreased from 30% to 6%; cocaine use decreased from 37% to 6%; and heroin use decreased from 24% to 6%.
- For clients in methadone maintenance, the percentage that used heroin in the previous month decreased from 92% to 25% (DHS OASA 2001).

Increased Employment Outcomes After Treatment

- The average number of days for which individuals receiving treatment were paid for working in the previous 30 days increased from 7.1 days to 10.7 days, using baseline and six-month follow-up data.
- The percentage of clients reporting employment problems in the previous 30 days improved, dropping from 47% before treatment (19.0 average number of days with problems) to 30% after treatment (11.6 average number of days with problems), using baseline and six-month follow-up data.

Source: Illinois Department of Human Services, Office of Alcoholism & Substance Abuse. (2001). *The Effectiveness of Substance Abuse Treatment in Illinois: Results of the Illinois Statewide Treatment Outcomes Project.* p. 42. Retrieved December 27, 2004, from http://www.dhs.state.il.us/oasa/Documents/oasaesati.pdf.

Key-Crest Study: In-Prison and Post-Prison Treatment

The State of Delaware, with support of the U.S. Department of Justice, Bureau of Justice Assistance, established the Key Program, a prison-based treatment program for drug-involved offenders at a men's maximum security prison. In this study, researchers conducted interviews with offenders before entering the Key Program about their past drug use, sexual activity, and criminal behavior. Researchers also conducted clinical interviews at the beginning and completion of the Key Program to determine participants' progress in treatment. Follow-up interviews involved four groups of offenders: a comparison group (received no treatment); a Key group (received only prison-based treatment); a Crest Group (received only treatment at a work-release center); and a Key-Crest group (received treatment in both the Key and the Crest programs).

- 18 months after release, drug offenders who received 12-15 months of treatment in prison followed by an additional 6 months of drug treatment and job training were more than twice as likely to be *drug-free* than offenders who received prison-based treatment alone (76% compared to 30%).
- Offenders who received both forms of treatment were much more likely than offenders who received only prison-based treatment to be *arrest-free* 18 months after their release (71% compared to 48 %).

Findings at 18-month Follow-up		
	Drug-Free	**Arrest-Free**
Comparison Group (no treatment)	19%	30%
Key Group (in-prison treatment only)	30%	48%
Crest Group: (treatment during work release only)	45%	65%
Key-Crest Group (both in-prison and treatment during work release)	76%	71%

Source: National Institute of Justice (1996). Inciardi, J. "A Corrections-based Continuum of Effective Drug Abuse Treatment.

GLATTC RESEARCH UPDATE: COERCED DRUG TREATMENT FOR OFFENDERS: DOES IT WORK?, SUBMITTED BY PAMELA RODRIGUEZ, EXECUTIVE VICE PRESIDENT, TREATMENT ALTERNATIVES FOR SAFE COMMUNITIES (TASC), INC.

GLATTC Research Update
Fall 2002

Coerced Drug Treatment for Offenders: Does It Work?

Over half of the people referred to community-based drug treatment programs are clients of criminal justice agencies and are classified as coerced clients. Studies show that coercion yields the same, if not better treatment results by motivating clients to stay in treatment longer, and giving treatment opportunities that may not be available otherwise.

Coercion means that a criminal justice offender is given a choice between entering and complying with a drug treatment program, or receiving alternative consequences prescribed by the law. Participation is mandatory and noncompliance is threatened with sanctions up to and including incarceration; other sanctions may include the loss of child custody, employment, and benefits.

Coercive treatment can be mandated at various stages of the criminal justice process and can be imposed with varying degrees of restrictiveness. Coercion can consist of a judge offering a defendant to choose between treatment or incarceration. Probation officers can recommend and enforce treatment as a court-imposed condition of probation. Or, prison administrators can place inmates involuntarily into drug treatment programs.

What began in the 1920s as an initiative for morphine addicts, these pioneering efforts were followed by mandatory federal narcotics treatment programs in the 1930s and civil commitment programs at the federal level in the 1960s. During that time, the New York and California state systems implemented coerced drug treatment programs. Today's form of coerced drug treatment programs began in the 1970s.

Today, a significant number of persons participating in publicly funded drug treatment programs in the United States are criminal offenders. In fact, approximately half of those people participating in publicly funded community-based treatment programs are clients of criminal justice agencies. High rates of clients engaging in coerced treatment require an investigation of its success.

Findings reveal that willingness to enter treatment is not a requirement for success. Addicts are aided by legal coercion because it helps them make decisions that they may not have been able to make on their own. Coercion is the leverage that can keep addicted offenders in treatment long enough to benefit from the positive effects of a supportive therapeutic experience, and become intrinsically motivated to remain and succeed. In addition, coerced treatment provides services for addicts which may otherwise have been unavailable to them.

"...the most incisive argument in favor of coerced treatment is that it works."

While these arguments are compelling, the most incisive argument in favor of coerced treatment is that it works. Studies repeated under varied conditions demonstrate the same, if not better results from coerced treatment as compared to voluntary treatment. This has been true among clients who receive treatment in their work setting, as well as those in the criminal and welfare populations. Findings also reveal that legally coerced clients benefit from treatment as much as voluntary clients even though they enter treatment with less favorable prognoses.

One key to coerced treatment success is Anglin and colleagues' findings when they reviewed eleven distinctive studies of coerced treatment programs. On the whole, coerced clients begin treatment sooner and remain in it longer than those who enter treatment voluntarily. Treatment retention is a critical variable in predicting recovery.

Other data corroborate this finding. The nationwide Drug Abuse Reporting Program Study (DARP) found that addicts who remained in treatment for more than 90 days were significantly less likely to use drugs in the year following treatment than those who were in treatment fewer than 90 days. Data from the twelve year follow-up interviews further supported this conclusion.

Finally, coerced treatment is associated with clear and substantial benefits such as decreased medical costs, decreased crime, and improved psycho-social and employment status. These findings demonstrate that criminal justice practitioners and drug treatment providers are cooperating effectively to produce enhanced treatment outcomes for addicted offenders.

Prepared by Arthur J. Lurigio, Ph.D.
For more information, contact the GLATTC Center for Excellence in Criminal Justice at (312) 573-8374.

GLATTC Research Update
Fall 2002

Sources:

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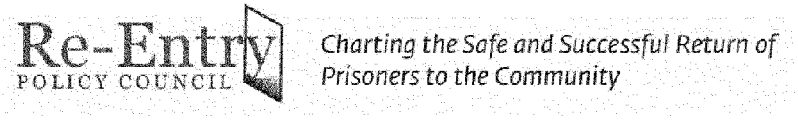

Substance Abuse and Re-Entry Statistics

- Eighty percent of state prisoners report a history of drug or alcohol use.[1] In fact, more than half (55 percent) of state prisoners report using drugs or alcohol during the commission of the crime that resulted in their incarceration.
- Two-thirds of convicted jail inmates were "actively involved in drugs" prior to their admission, and 36 percent were using drugs or alcohol at the time of their offense.[2]
- Today, the percentage of people released from prison following a conviction for a drug offense is twenty percent higher than it was in 1984, totaling about one-third of all released prisoners.[3]
- Nationally, only ten percent of state prisoners in 1997 reported receiving formal substance abuse treatment during their incarceration, down from 25 percent in 1991.[4]
- Only three percent of jail inmates participate in formal treatment while incarcerated.[5]
- Inmates who participate in residential treatment programs while incarcerated have 9 to 18 percent lower recidivism rates and 15 to 35 percent lower drug relapse rates than their counterparts who receive no treatment in prison.[6]
- In-prison drug treatment has been associated with positive outcomes, including reduced use of injection drugs, fewer hospital stays for drug and alcohol problems, and decreased recidivism rates.[7] The most successful outcomes are found for those who participate in both in-prison treatment and postrelease treatment in the community.[8]
- A study conducted in California reported that treating offenders for $209 million saved taxpayers more than $1.5 billion 18 months later, with the largest savings due to reductions in crime.[9] The study estimated that for every $1 spent on treatment, approximately $7 could be gained in future savings.

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