

# TCE NEWS

ELEVENTH EDITION  
DECEMBER 2001

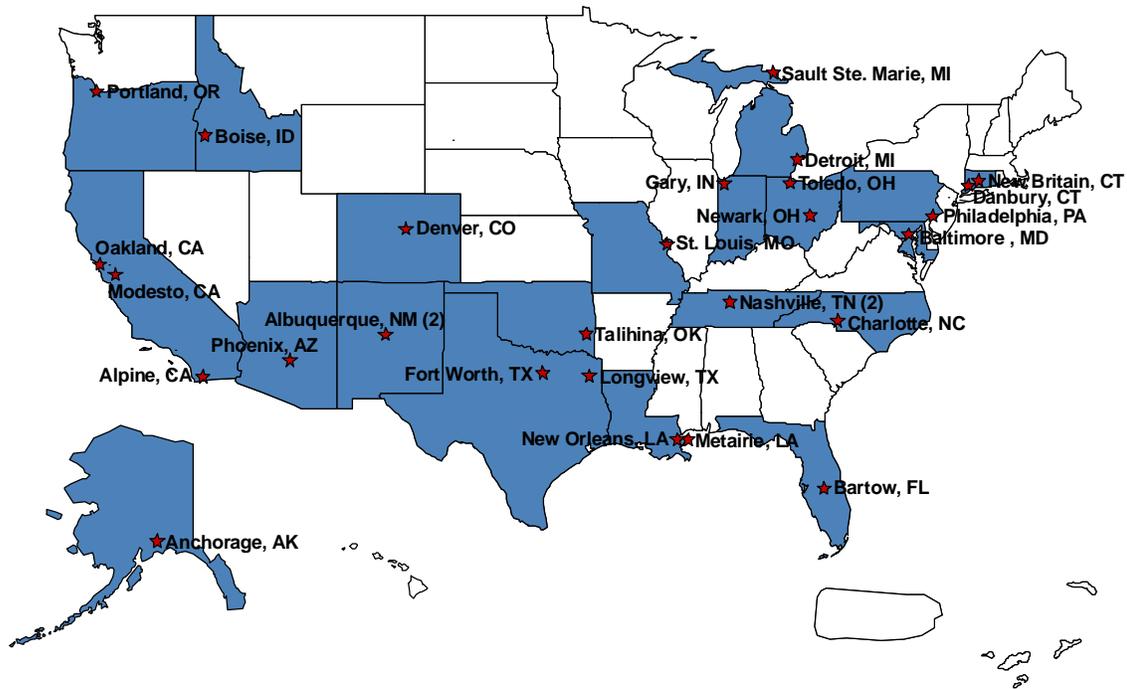
## T A R G E T E D C A P A C I T Y E X P A N S I O N

### DECEMBER 2001 - WELCOME NEW GRANTEEES!

The Center for Substance Abuse Treatment is proud to welcome the 53 new TCE, TCE HIV, and HIV Outreach grantees. You are now a member of 269 CSAT grantees charged with expanding treatment services in their communities. Of these 269 grantees, 141 grantees are in the TCE program, 79 grantees are in the TCE HIV program, and 49 grantees are in the HIV Outreach program. This diverse group of grantees serves many target populations, including all age groups, many racial and ethnic groups, and the disabled. The projects provide treatment services, make referrals, and engage in outreach activities.

New grantees will receive detailed instructions concerning the submission of quarterly reports and data under the Government Performance and Results Act (GPRA); a description of the cluster groups that the new grantees will join; information about the TCE and cluster group LISTSERVs; procedures for requesting technical assistance; and information about future TCE-related meetings. Again, welcome to CSAT.

### Center for Substance Abuse Treatment 2001 Targeted Capacity Expansion Grantee Sites (N=29)



**CSAT**

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Substance Abuse and Mental Health Services Administration

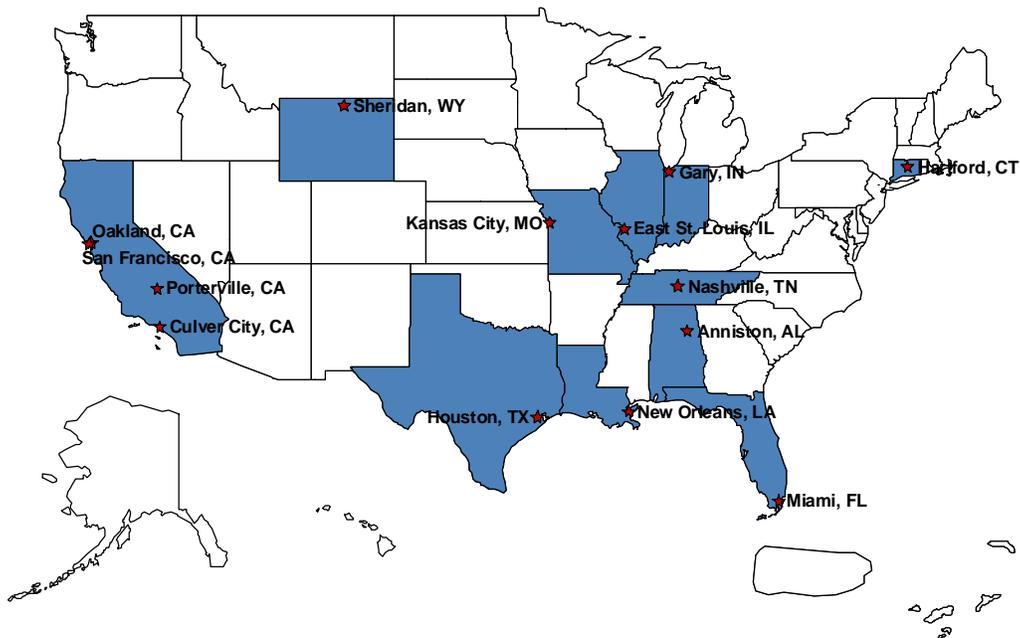
Center for Substance Abuse Treatment

Center for Substance Abuse Treatment  
SAMHSA

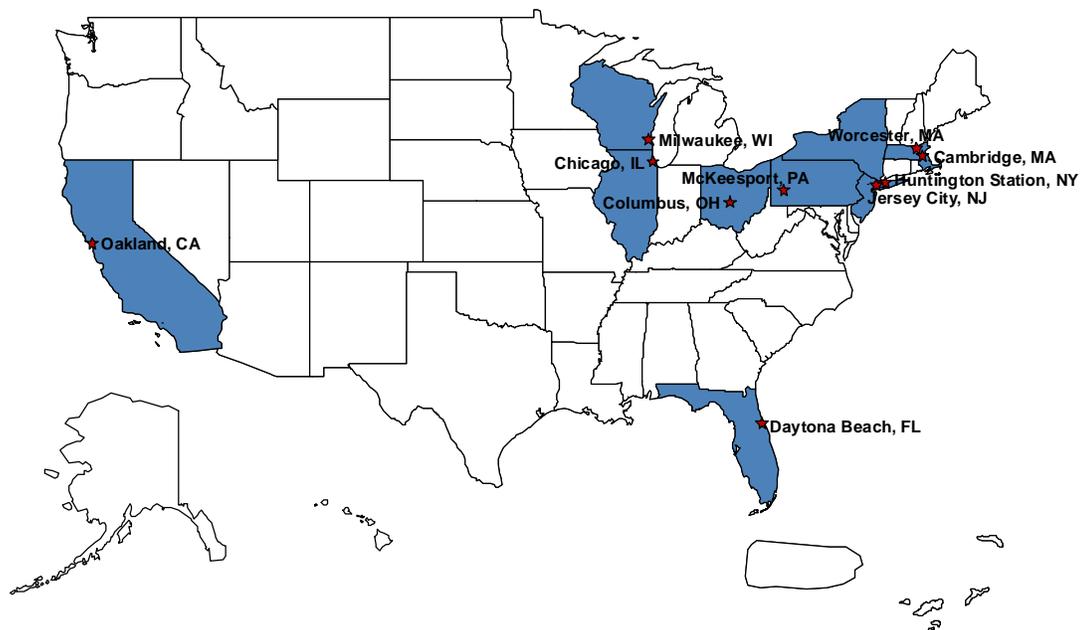
Produced under a contract funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, 5600 Fishers Lane, Rockwall II, Suite 618, Rockville, Maryland 20857, 301.443.5052

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**Center for Substance Abuse Treatment  
2001 Targeted Capacity Expansion HIV Grantee Sites (N=14)**



**Center for Substance Abuse Treatment  
2001 Targeted Capacity Expansion HIV Outreach Grantee Sites (N=10)**



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**FAREWELL TO THE 1998 GRANTEEES!**

It is always difficult to say goodbye to colleagues who have worked closely with you for an extended period of time. It is like saying goodbye to old friends. So, it is with a heavy heart that we say farewell to some of the 1998 grantees. On behalf of your communities and CSAT, we sincerely thank you for your efforts.

**METHAMPHETAMINE USE IN THE WESTERN UNITED STATES:  
AN IN-DEPTH LOOK**

Over the past several years, the Office of National Drug Control Policy's Pulse Check series has reported the increase and spread of methamphetamine use in west coast states. To gain more in-depth information concerning this trend, a special Pulse Check study was conducted in six states that appear to have been affected the most by methamphetamine - Arizona, California, Hawaii, New Mexico, Oregon, and Washington. Drug ethnographers, law enforcement officials, and treatment providers in each state were interviewed to determine the nature and extent of methamphetamine use in this region of the country.

**What is the Level of Methamphetamine Use?**

Ethnographers, law enforcement officials, and treatment providers in all six states reported that methamphetamine use was a high-priority problem. On average, 27 percent to 55 percent of treatment admissions in each of the states were methamphetamine users. In several areas, methamphetamine has surpassed alcohol and cocaine as the primary drugs of abuse among treatment admissions. Interestingly, all states reported that the primary reason for methamphetamine clients' entry into treatment was legal problems, such as "aggressive behaviors like fighting or bizarre or inappropriate behaviors which prompt others to call the police" (p. X).

**Who is Using Methamphetamine?**

In five of the six states, the majority of methamphetamine users are described by sources as white males in their 20s and 30s who are blue collar workers or unemployed. However, there have been recent increases in use among youth, Native American, and Hispanic populations. Hawaii was the only one of the six states to report a wide range in the types of users; "while many [treatment] programs report that users are young (teens and twenties), there is a range of jobs, ethnicities, and education levels reported" (p. IX).

**How is Methamphetamine Being Used?**

Patterns of use varied across the six states. According to treatment data, snorting and smoking were the most common modes of ingestion in California and Arizona, while the majority of treated users in Oregon and New Mexico preferred snorting or injecting the drug. In Hawaii, no treatment programs reported that clients injected; 81 percent reported that clients smoked the drug. Treatment providers in Washington State reported that clients were equally likely to smoke, snort, or inject methamphetamine. Some unique modes of ingestion were also reported. In California, "putting methamphetamine into coffee is what is termed 'biker's coffee' is reported by ethnographic sources as popular among young professionals interested in the drug's energizing and appetite suppressant effects" (p. III). Eating methamphetamine (putting methamphetamine on paper or food and chewing it) was reported by a law enforcement source in Washington State.

Source: Adapted by CESAR from data from the Office of National Drug Control Policy (ONDCP), Pulse Check: National Trends in Drug Abuse, Summer 1997. To receive a complimentary copy, call the ONDCP Drugs and Crime Clearinghouse at 1-800-666-3332. For more information, contact Dr. Dana Hunt of Abt Associates at 617-492-7100.

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**R E M I N D E R**

**QUARTERLY REPORTS** should be submitted on time. Any delays must be cleared with your CSAT Project Officer. We look forward to receiving your reports by January 31, 2002. If you need assistance in any way, please call Aaron Benton at (703) 575-4995. Thank You.  
 ACS Federal Healthcare/Birch & Davis Associates, Inc.  
 CSAT Team

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**CSAT'S TRACKING AND LOCATING TRAINING LAUNCHED**

In an effort to satisfy the grantees' technical assistance requests for help with finding clients and conducting GPRA 6- and 12-month follow-up interviews, CSAT offered regional Follow-up Tracking and Locating trainings to the Targeted Capacity Expansion (TCE), TCE HIV, and HIV Outreach grantees. During October and November 2001, CSAT held a total of 15 trainings in twelve cities for projects funded in FY 1999 and 2000. They scheduled additional trainings for the continuing FY 1998 grantees in December 2001 and for the FY 2001 grantees in February 2002.

The Follow-up Tracking and Locating training was developed and conducted by ACS Federal Healthcare, Inc. (FHC), in conjunction with the University of California, Los Angeles Drug and Alcohol Research Center (UCLA DARC), and other experts in the field. The trainers include researchers and program staff with years of experience in tracking and locating, and with excellent follow-up rates. The training offers concrete strategies for obtaining useful client locator information at intake, as well as strategies for tracking clients electronically, by telephone, through criminal justice records, and through numerous other public documents and records. From a smorgasbord of techniques and strategies, participants are encouraged to select, use, and tailor strategies to fit their target populations, projects, agencies, and communities. The training also covers confidentiality, safety in the field, adequate planning (e.g., resources, staffing, training) for successful follow-up, and tips for motivating staff responsible for tracking and locating clients.

Training staff distributed CSAT's manual, *Staying In Touch: A Fieldwork Manual of Tracking Procedures for Locating Substance Abusers for Follow-up Studies*, to one staff member from each project. Developed by the UCLA DARC and the National Evaluation Data and Technical Assistance Center (NEDTAC), the manual detailed all the techniques covered in the training, as well as additional techniques, sample forms, and contact information for tracking and locating resources.

Overall, the feedback and evaluations from the trainings have been very positive. Although the training participants' levels of experience and success varied widely, an overwhelming majority of the participants reported learning new strategies and techniques that they planned to implement in their projects. Even the participants with a great deal of follow-up experience reported that they learned something new and that the training validated some of the follow-up strategies that they were already using. Quite a few participants remarked that they wished the training had been offered earlier.

CSAT's *Staying In Touch: A Fieldwork Manual of Tracking Procedures for Locating Substance Abusers for Follow-up Studies* may be downloaded from the NEDTAC Web site: [www.neds.calib.com/products](http://www.neds.calib.com/products)

Written by Miriam E. Phields, PhD

**FACTS ABOUT PRESCRIPTION DRUG ABUSE AND ADDICTION**

Prescription drugs can help patients manage chronic or severe pain, restore emotional or behavioral balance, control sleep disorders, or fight obesity. When prescription medications are abused, however, the consequences—including addiction—can be dangerous, even deadly. The National Institute on Drug Abuse's (NIDA) newest Research Report focuses on the risks associated with abuse of three classes of commonly abused prescription drugs: opioids; central nervous system (CNS) depressants, including sedatives and tranquilizers; and stimulants.

**What Are Opioids And What Are The Potential Consequences Of Their Use And Abuse?**

Opioids, include morphine, codeine, and related drugs such as oxycodone (OxyContin), hydrocodone (Vicodin), and meperidine (Demerol) and are commonly prescribed to relieve pain. Opioids can produce drowsiness and, in higher doses, depress respiration. Opioid drugs also can cause euphoria.

Taken as prescribed, opioids can be used to manage pain effectively without untoward side effects. Chronic use of opioids can result in tolerance, which means that users must take higher doses to achieve the same effects. Long-term use also can lead to physical dependence and addiction; withdrawal can occur when an individual discontinues use of the drugs. Withdrawal symptoms may include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes with goose bumps, and involuntary leg movements. Individuals who are addicted to opioids are more likely to overdose on the drugs, which could be fatal.

**What Are CNS Depressants and What Are The Potential Consequences of Their Use and Abuse?**

Among the most commonly prescribed CNS depressants are barbiturates, such as mephobarbital (Mebaral) and pentobarbital sodium (Nembutal), which are prescribed to treat anxiety, tension, and sleep disorders; and benzodiazepines, such as diazepam (Valium) and alprazolam (Xanax), which typically are prescribed to treat anxiety, acute stress reactions, and panic attacks. Other

benzodiazepines, such as triazolam (Halcion) and estazolam (ProSom), are prescribed for short-term treatment of sleep disorders.

Although the various classes of CNS depressants work differently, they all produce a beneficial drowsy or calming effect in individuals suffering from sleep disorders or anxiety. If one uses these drugs over a long period of time, the body will develop tolerance, and larger doses will be needed to achieve the initial effects. In addition, continued use can lead to physical dependence and, when use is reduced or stopped, withdrawal. Both barbiturates and benzodiazepines have the potential for abuse and should be used only as prescribed. As with opioids, overdose of these drugs can be fatal.

### **What Are Stimulants and What Are The Potential Consequences of Their Use and Abuse?**

Stimulants enhance brain activity, increasing alertness, attention, and energy, raising blood pressure, and elevating heart rate and respiration. Stimulants such as methylphenidate (Ritalin) and dextroamphetamine (Dexedrine) are prescribed for the treatment of narcolepsy, attention-deficit/hyperactivity disorder, and depression that has not responded to other treatments. They also may be used for short-term treatment of obesity.

Individuals may become addicted to the sense of well-being and enhanced energy that stimulants can generate. Taking high doses of stimulants repeatedly over a short time, however, can lead to feelings of hostility or paranoia. Additionally, taking high doses of stimulants may result in dangerously high body temperatures and an irregular heartbeat.

### **To Receive This Resource**

Copies of the NIDA Research Report "Prescription Drugs: Abuse and Addiction" may be ordered from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686 or TDD 1-800-487-4889 for the hearing impaired. Additional information on prescription drug abuse can be obtained through NIDA's Web site at [www.drugabuse.gov](http://www.drugabuse.gov).

## **WHAT'S NEW?**

### **Scientists Show Marijuana Use Affects Learning, Other Memory Skills**

Researchers at the McLean Hospital/Harvard Medical School have found that heavy, long-term marijuana use produces memory impairment for days or even weeks after users stop smoking.

To ascertain the effects of marijuana use on memory and other cognitive skills, the Harvard research team recruited 180 individuals between the ages of 30 and 55 years. About one-third of the subjects were current heavy users who had smoked marijuana at least 5,000 times in their lives (equivalent to using the drug at least once a week for 13 or more years) and who were smoking daily at the time they entered the study; another third were former heavy users. Individuals in the control group had used marijuana at least once but fewer than 50 times in their lives.

All of the subjects were asked to abstain from marijuana for 28 days, and their drug abstinence was confirmed by urine samples. They were administered a battery of tests to assess general intellectual function, abstraction ability, attention span, verbal fluency, and ability to learn and to recall new verbal and visuospatial information just before and then on the 1st, 7th, and 28th days of abstinence. At days 0, 1, and 7, current heavy users of marijuana scored significantly lower than the control subjects on recall of word lists, but by day 28, there were virtually no differences among the groups on any of the tests. Cognitive deficits were detectable at least seven days after heavy marijuana use, but these changes appeared to dissipate within a few weeks, after tetrahydrocannabinol (THC), the active ingredient of marijuana, and its metabolites have cleared the body.

**WHAT IT MEANS:** This study clearly points out that marijuana is not a benign substance. By impairing memory and other cognitive functions, smoking marijuana can negatively affect academic achievement and other life skills.

Lead investigator Dr. Harrison G. Pope, Jr. published the study in the October 2001 issue of *Archive of General Psychiatry*.

### **Early Age at First Drink May Reflect Genetic Risk For Later Substance Abuse**

The age at which an individual takes his/her first drink is strongly predictive of a broad range of future problem behaviors, including alcoholism, abuse of illicit drugs, conduct and antisocial personality disorders, nicotine addiction, underachievement in school, and poor impulse control, according to researchers from the University of Minnesota.

The head of the Minnesota research team, Dr. Matt McGue, says the team's findings indicate that there may be a common genetic basis for a number of behavioral problems, and an early age for the first use of alcohol could be a "marker" for a genetic risk for these problems.

The researchers also found that early use of alcohol tends to run in families, and, at least in males, it is an inheritable trait. There were significantly more conduct disorders and other behavioral problems in the sons than in the daughters of parents whose age at first drink came before age 15. For girls, shared environmental

factors, rather than age at first drink, appeared to be more of a determining factor.

**WHAT IT MEANS:** Age at first drink may prove to be helpful in identifying teens who are at risk for future substance abuse and other programs, permitting them to be targeted for early, intensive prevention and intervention programs.

The research is published as two separate papers in the August 15, 2001 issue of *Alcoholism: Clinical and Experimental Research*.

### **Adult Male Mice Exposed to Methamphetamine in Utero Have Increased Neurotoxicity Risk**

Researchers at the University of Chicago, in experiments with mice, have found that prenatal exposure to methamphetamine increases response to the toxic effects of the drug in adult males. Some effects of prenatal methamphetamine exposure were observed in female offspring, but were much less than those seen in the males.

The investigators say these findings may raise concerns for male methamphetamine abusers whose mothers used the drug while pregnant. The neurotoxic risk from using methamphetamine as adults may be greater for men who were exposed prenatally. Methamphetamine toxicity is characterized by persistent decreases in the levels of dopamine and serotonin in certain brain regions. It is known that in humans, dopamine deficits are associated with symptoms of Parkinson's disease.

**WHAT IT MEANS:** This finding, coupled with the increasing use of club drugs, such as methamphetamine, by women of childbearing age, makes this issue a potential public health concern.

The researchers, led by Dr. Alfred Heller, published their findings in the August 2001 issue of the *Journal of Pharmacology and Experimental Therapeutics*.

### **EEG Shown to Reliably Predict Drug and Alcohol Relapse Potential**

A University of Connecticut School of Medicine researcher has found that use of quantitative electroencephalography (EEG) is a reliable tool to predict which patients with histories of abuse of alcohol, cocaine, cocaine and alcohol, or opioid dependence are prone to relapse.

EEGs were given to 107 substance-dependent patients enrolled in a treatment program and to 22 controls with no history of substance abuse. An electroencephalogram was administered when the patients had been free of alcohol or drug use for an average of 3 months. The patients were then monitored for the next 6 months to see if they resumed alcohol or drug use.

The researcher observed that the 48 patients who relapsed to substance abuse shared a similar characteristic - their EEGs showed an increased amount of high-frequency activity, compared to the 59 patients who maintained abstinence and to the 22 control subjects. This high-frequency on the EEGs was found to far outweigh clinical and demographic variables as a predictor of relapse.

**WHAT IT MEANS:** EEGs may prove to be a sensitive and specific screening test that can be used to identify those substance abuse patients with the highest risk of relapse. This would be an important advance for treatment planning because it would permit prevention and treatment efforts to be directed toward those at the highest risk for relapse. EEG technology is more practical and affordable than other neuroimaging technologies, including FMRI, PET, or SPECT, and it can realistically be implemented into a variety of treatment settings.

The study by Dr. Lance Bauer, Professor of Psychiatry and Director of the Neural Dynamics Laboratory at the University of Connecticut, was published in the July 2001 issue of the *Journal of Neuropsychopharmacology*.

**Study Finds Combination Therapy May Help Those With a History of Recurrent Depression to Quit Smoking**  
Researchers at the Brown University School of Medicine have found that smokers with a history of recurrent major depressive disorder (MDD) who received standard treatment for smoking cessation - combined with behavioral coping therapy for depression - were more likely to be successful in quitting than those receiving standard treatment alone. Interestingly, heavy smokers also benefitted from the inclusion of therapy for depression in their stop-smoking treatment regimen, regardless of their history of depression.

The researchers recruited 179 smokers, more than half of whom were women, between the ages of 18 and 70 years. All had a history of MDD; some had experienced a single episode, while others had experienced recurrent bouts of depression. Participants were currently smoking an average of 27 cigarettes per day and on average had been smokers for more than 27 years. A year after a 6-week treatment program, 24.7 percent of the standard therapy group - compared to 32.5 percent of the combination therapy group - had stopped smoking. The study found that individuals with a history of recurrent episodes of depression had poorer treatment outcomes than did those with only a single episode of depression.

**WHAT IT MEANS:** This study indicates that incorporating treatment for depression into standard smoking cessation therapy may be beneficial for smokers with a history of recurrent MDD and for those who smoke

heavily.

The study, led by Dr. Richard Brown of the Brown University School of Medicine, appears in the May 2001 issue of *Journal of Clinical and Consulting Psychology*.

Source for What's New: National Institute on Drug Abuse - NewsScan for October 16, 2001.

**THE NATIONAL LEADERSHIP INSTITUTE:  
AN OVERVIEW**

The National Leadership Institute (NLI), an initiative funded by the Center for Substance Abuse Treatment (CSAT), provides management and business consulting to nonprofit substance abuse treatment providers. Since 1998, CSAT's NLI has provided on- and off-site technical assistance (TA) and training services to providers, helping them in the areas of board development, accreditation, strategic and financial planning, performance contracting, network development, data collection and analysis, and reporting. In addition to onsite TA, NLI also provides the following information and tools through its Web site:

- a. **Strategic Management Tools**—Forms, checklists, sample policies, and other instruments you can use or adapt for your organization's needs.
- b. **Ask the Expert**—A Q&A forum covering business and management issues.
- c. **Business and Management Compendium Database**—An online search tool to find Internet resources, books, articles, and other materials.
- d. **NLI Research Service**—A source that can supply the information you need. Fill out a research request form and one of NLI's librarians will do the research for you.
- e. **TA Tips**—A series of "how-to" articles covering the basics on a wide variety of management topics.
- f. **Feature Articles**—Stories that take an in-depth look at a topic or provide interviews with leaders in various fields.
- g. **Focus Area Briefcases**—Single-topic areas, covering issues such as human resources, grants and funding, communication, and accreditation.

For more information, call 800-411-0814 or visit NLI online at [www.samhsa.gov/nli](http://www.samhsa.gov/nli).

Article provided by: Ms. Holly Brooks Johnson, Bassin & Shaw, Inc.

**CONFERENCE CALENDAR CORNER**

**JANUARY**

**January 8-12, 2002 - Tampa, Florida 813-632-1414**  
Cancer, Culture and Literacy Institute  
H. Lee Moffitt Comprehensive Cancer Center  
Vicki Sluster

**January 31-February 3, 2002-San Antonio, Texas 703-838-0500**  
Women's Health, Women Doctors, and the Politics of Universal Healthcare  
The Adams Mark Hotel  
Jannine Jordan

**FEBRUARY**

**February 6-7, 2002 - Atlanta, Georgia 770-488-8225**  
Task Force on Community Preventive Services  
Sheraton Colony Square  
Julie Ann Wasil

**February 7, 2002 - New York, New York 212-841-5215**  
Dangerous Liaisons: Substance Abuse and Sexual Behavior  
The Henry J. Kaiser Family Foundation, NIDA, and National Institute of Mental Health  
Zena and Michael A. Wiener Conference Center at Columbia University  
Sarah Winkler

**February 10-11, 2002 - Montgomery, Alabama 334-262-1629**  
International Conference on Addictions  
Council on Substance Abuse-NCADD  
Kristopher Vilamaa

**February 16-19, 2002 - Washington, DC 202-261-4120**  
National Youth Summit on Preventing Violence  
National Crime Prevention Council  
Kellie Foster

**MARCH**

**March 4-7, 2002 - San Diego, California 404-639-8260**  
2002 National STD Prevention Conference  
Town & Country Hotel and Conference Center  
Glenda Vaughn

**March 24-27, 2002 - Atlanta, Georgia 404-639-4581**  
International Conference on Emerging Infectious Diseases  
Hyatt Regency Atlanta

ACS Federal Healthcare, Inc./Birch & Davis  
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 3 Skyline Place, Suite 600  
 Falls Church, Virginia 22041-3299  
 (703) 820-4810, (703) 671-0246 (fax)

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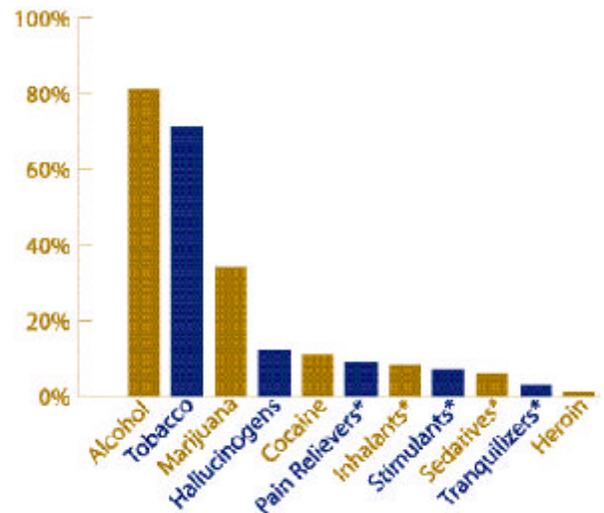


NEWS

T A R G E T E D C A P A C I T Y E X P A N S I O N

DATA BITES

Estimated Percentage of U.S. Household Residents (Age 12 and Older) Reporting Lifetime Use of Alcohol, Tobacco, and Other Drugs, 2000



\*Nonmedical use only; does not include over the counter drugs.

Majority of U.S. Household Residents Have Used Alcohol and Tobacco, One-Third Report Having Tried Marijuana

Alcohol, tobacco, and marijuana are the most frequently used drugs among household residents, according to the recently released 2000 National Household Survey on Drug Abuse. Eighty-one percent of household residents 12 or older report that they have used alcohol at least once in their lifetime and 71 percent report lifetime tobacco use. Just over one-third — an estimated 76.3 million people—report using marijuana at least once in their lifetime. Other drugs used by 10 percent or more of householders were hallucinogens, cocaine, pain relievers, inhalants, stimulants, and tranquilizers. The full report is available online at [www.samhsa.gov/oas/oas.html](http://www.samhsa.gov/oas/oas.html).

SOURCE: Adapted by CESAR from Office of Applied Studies, Substance Abuse and Mental Health Administration, Summary of Findings from the 2000 National Household Survey on Drug Abuse, 2001.

RESEARCH FILE

**Residential Treatment In A Therapeutic Community May Reduce Future Incarceration: A Research Note**

**1. Introduction**

Collective incapacitation (i.e., offense-based imprisonment policy) is the primary strategy for crime control in the United States. Increased reliance on collective incapacitation has resulted in the tripling of the United States prison populations since 1980 (Beck, 1999; Cohen & Canela-Cacho, 1994). The enactment of new laws that increase the certainty and severity of punishment has predominately targeted drug crimes. Recent estimates from the Arrestee Drug Abuse Monitoring Program (ADAM) are that 68 percent of the arrestees in the United States test positive for one or more drugs (NIJ, 1999). From 1980 to 1990, the likelihood of incarceration after arrest increased fivefold for drug offenses (Beck, 1999), most notably in the Federal system (Mauer, 1997). In fact, 61 percent of the Federal prison population was comprised of drug offenders as of 1995 (Mauer, 1997).

There are several consequences of incapacitation policies for drug offenses. First, these policies have contributed to large increases in criminal justice costs, because of substantial increases in prison populations. At year-end 1996, 1.1 million adults were in custody in State or Federal prisons (Beck, 1999). National corrections costs, including probation and parole, are currently more than \$30 billion annually (Mauer, 1997). Continued imprisonment of drug users will require building new prisons at an estimated cost of about \$75,000 per prison cell (Blumstein, 1995).

Many social scientists recognize the inability of traditional criminal justice policies to deal with the extensive drug problem in this country (Mauer, 1997). Fishbein (1990) contends that mandatory minimum sentences designed to "get tough" on drug crime have had limited success because they fail to address the underlying problems of addiction. The recent development of over 275 drug courts across the United States indicates a growing acceptance that court-ordered, community-based treatment may be a promising alternative to incapacitation (Dcschenes, Turner, & Greenwood, 1995). Zimring and Hawkins (1995) state that crime reduction by means of imprisonment lasts no longer than the last day of incarceration. The authors claim that influencing behavior through appropriate treatment will have a greater likelihood of reducing crime by that offender. One alternative to incarceration may be placement in a

residential Therapeutic Community (TC). In this paper we use findings from the District of Columbia Treatment Initiative (DCI) to look at whether completing treatment in a residential Therapeutic Community (TC) might be an effective strategy for reducing the likelihood of a subsequent incarceration.

**2. The District Of Columbia Treatment Initiative (DCI)**

The DCI was a randomized experiment designed to test the efficacy of providing Therapeutic Community (TC) treatment and subsequent outpatient treatment of different lengths and intensity to clients entering treatment in Washington, D.C. An extensive follow-up study of DCI clients re-interviewed 93 percent (n=380) of the target population an average of 19 months after release from treatment (Nemes, Wish, & Messina, 1999). A more detailed description of the DCI appears in Nemes, Wish, and Messina (1998). As part of this outcome study, we found that treatment completion was related to marked reductions in drug use and post-discharge arrests, as well as increased employment at follow-up (Nemes et al., 1999).

We also discovered that clients interviewed in the community were much more likely to have completed treatment than clients interviewed in prison (44 percent versus 10 percent). It appeared reasonable to hypothesize that treatment completion had reduced the likelihood of being incarcerated at follow-up. We first considered the obvious possibility that this relationship was circular, with clients being terminated from treatment after they had been arrested and incarcerated. Yet, we found that only four clients in our sample reported being terminated from treatment because of an arrest. We excluded these four clients from further analysis, leaving a final sample of 376 clients.

**Coefficients of Logistics Regression Assessing Incarceration at Follow-up (N=267)**

| Variables                                      | BETA    | P-Value | EXP (B) |
|------------------------------------------------|---------|---------|---------|
| Age                                            | -.1071  | .01     | .8984   |
| Total Prior Arrests                            | -.0458  | .16     |         |
| C.J. Status at Admission<br>[None]             |         |         |         |
| Probation, Parole, Bail, Jail                  | 2.7419  | .01     | 15.5168 |
| Primary Drug Disorder<br>Alcohol/Marijuana/PCP |         |         |         |
| Cocaine                                        | -1.1972 | .14     |         |
| Heroin & Cocaine                               | -1.4805 | .09     |         |
| Prior Drug Treatment<br>[No]                   |         |         |         |
| Yes                                            | .03334  | .94     |         |
| Treatment Status<br>[Did Not Graduate]         |         |         |         |
| Graduated                                      | -2.3224 | .01     | .0980   |
| Constant                                       | 1.0939  | .45     |         |

Note: [Brackets] indicate reference category.

### 3. Results

We used bivariate analyses to identify factors that were associated with incarceration at follow-up and immediately found that only 6 percent of the 105 women were incarcerated at follow-up compared with 24 percent of the men. Due to the very low number of women incarcerated (n=6), we limited our analyses to the 271 male clients.

In addition to treatment completion status, we looked at a number of demographic, criminal history, and substance abuse history variables collected at treatment admission that we thought might be related to post-treatment incarceration. Exhibit 1 shows that 6 of the 10 variables that we examined were significantly related to being incarcerated at follow-up. Most notably, men who dropped out of treatment, who were under 25 years old at admission, and who had extensive involvement with the criminal justice system prior to treatment, were most likely to be incarcerated at follow-up.

Logistic regression analysis was performed to determine the degree of the association between treatment completion and incarceration at follow-up while controlling for significant client characteristics and other related factors found in the bivariate analyses. Exhibit 2 shows that two treatment admission variables, age and criminal justice status, remained significantly related to incarceration at follow-up (drug disorder at admission, prior drug treatment, and total prior arrests were no longer significant). Each 1 year increase in the age of a client reduced the odds of being incarcerated by 10 percent. However, formal criminal justice supervision at treatment admission (i.e., probation, parole, on bail, or in jail) increased the odds of incarceration at follow-up by over 1,000 percent.

After controlling for treatment admission variables, treatment completion remained significantly related to incarceration at follow-up. Completing treatment reduced the odds of being incarcerated at follow-up by 90 percent (this translates into an average 10 percent probability of being incarcerated at follow-up for treatment completers across all predictors in the model versus an average 51 percent probability for treatment drop-outs).

**Percent of Men Incarcerated at Follow-up, By Client Characteristics (N=271)<sup>ab</sup>**

| Characteristics                     | Incarcerated % | P-Value |
|-------------------------------------|----------------|---------|
| Age at Admission                    |                | .01     |
| 19-25 (44)                          | 48%            |         |
| 26-30 (86)                          | 24%            |         |
| 31-35 (71)                          | 18%            |         |
| 36-40 (41)                          | 20%            |         |
| >41 (29)                            | 7%             |         |
| Education at Admission              |                | .22     |
| 11 years or less (176)              | 26%            |         |
| 12 years (44)                       | 25%            |         |
| Ever Had Legitimate Job             |                | .35     |
| Yes (245)                           | 23%            |         |
| No (24)                             | 29%            |         |
| Marital Status at Admission         |                | .09     |
| Married/Living As (41)              | 17%            |         |
| Divorced/Separated (38)             | 13%            |         |
| Never Married (190)                 | 27%            |         |
| Primary Drug Disorder               |                | .01     |
| Alcohol/Marijuana/PCP (13)          | 54%            |         |
| Cocaine (112)                       | 21%            |         |
| Heroin & Cocaine (102)              | 16%            |         |
| Prior Treatment                     |                | .05     |
| Yes (123)                           | 19%            |         |
| No (145)                            | 28%            |         |
| Total Prior Arrests                 |                | .01     |
| 0-1 (33)                            | 0%             |         |
| 2-5 (68)                            | 19%            |         |
| 6-9 (74)                            | 30%            |         |
| >10 (95)                            | 32%            |         |
| C.J. Status at Admission            |                | .01     |
| None (78)                           | 4%             |         |
| Probation, Parole, Bail, Jail (192) | 32%            |         |
| SCID Diagnosis                      |                | .23     |
| No Disorder (47)                    | 21%            |         |
| Provisional Only (26)               | 31%            |         |
| Other Disorders (16)                | 6%             |         |
| Depression (15)                     | 33%            |         |
| APD (101)                           | 21%            |         |
| APD & Depression (22)               | 9%             |         |
| Treatment Program Status            |                | .01     |
| Did Not Graduate (173)              | 36%            |         |
| Graduated (98)                      | 7%             |         |

<sup>a</sup> Excludes clients terminated from treatment due to arrest.

<sup>b</sup> Numbers vary slightly due to missing data.

### 4. Discussion

Our findings suggest that completion of treatment was associated with considerable reductions in incarceration at follow-up in this high risk population. Even after controlling for the large negative effect of being under formal criminal justice supervision at admission, completing treatment remained an important factor associated with substantially lower probabilities of incarceration. This result is consistent with our prior findings indicating that

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treatment completion was related to a number of other positive outcomes at follow-up (Nemes et al., 1999), even after controlling for a multitude of other variables related to treatment outcomes, such as inpatient treatment services (Nemes, Messina, Wish, & Wraight, 1999), gender (Messina, Wish, & Nemes, submitted), and antisocial personality disorder (Messina, Wish, & Nemes, 1999). Although our findings indicate that treatment completion is associated with a reduced likelihood of being incarcerated at follow-up, it is difficult to identify the mechanism behind these findings. Is it treatment completion or client compliance that is most important? Clients who are motivated to complete treatment could also be the most motivated to do well after treatment.

Regardless of the "completion versus compliance" dilemma, the findings from this study should be replicated. If persons who complete treatment in a Therapeutic Community (TC) are less likely to be incarcerated at follow-up, residential treatment may be one answer to the rising costs of the criminal justice system in the United States, as well as to the huge social costs to minority populations.

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