HB
329

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: January 16, 1998

FURTHER REFERRALS: Judiciar
Financ

Date of Committee Action: 3/10/98

The STATE AFFAIRS Committee considered: HB 32

HOUSE BILL NO. 329

HARBORVIEW DEVELOPMENTAL CENTE

"An Act amending the definition of correctional facility to include a therapeutic treatment center; providing for th conveyance of the Harborview Developmental Center and appurtenant land to the City of Valdez for the purpose o conversion and lease of a part of the center for a therapeutic treatment center for the Department of Corrections providing that such a land conveyance counts toward the general grant land entitlement of the City of Valdez; and providing for an effective date."

recommends it be replaced with the following committee substitute ______________ [ ] the same title [ ] a new title

[ ] additional referral to ______________ Committee
[ ] attached amendment(s)

ADOPTS: ______________ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[✓] fiscal note(s) Corrections

[✓] zero fiscal note(s) DNR, HSS Admin

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) ______________

[ ] zero fiscal note(s) ______________

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Jeannette James			✓	
[signature]	✓			
[signature]	✓			
[signature]		✓		
[signature]			✓	

CHAIR'S SIGNATURE Jeannette James

HB 329

TONY KNOWLES
GOVERNOR

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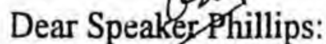
STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 16, 1998

The Honorable Gail Phillips
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182



Dear Speaker Phillips:

Nearly 80 percent of all crimes committed in Alaska involve substance abuse. Ensuring safe, healthy communities for Alaskans means having treatment programs designed to reduce the number of people who are victimized by persons under the influence of alcohol or drugs. In line with that effort, this bill authorizes the transfer of the Harborview Developmental Center to the City of Valdez for conversion, in part, to a therapeutic treatment center. The Department of Corrections would then lease the facility from the City of Valdez, which has agreed to invest considerable resources into the necessary conversion.

The Department of Corrections currently has three types of inmate substance abuse programs: substance abuse education, education plus an introduction to treatment, and institutional outpatient treatment. The department needs to complete its continuum of care by establishing an intensive in-prison program that treats the most severe substance abusers.

The Department of Corrections proposes to use a part of the soon-to-be-vacated facility for an intensive substance abuse treatment program, commonly referred to as a "therapeutic community". In 1997, the United States Department of Justice reported studies show consistent reductions in recidivism rates for offenders who complete such programs while in prison. That would also result in fewer crime victims.

There are currently between 90 and 110 incarcerated inmates who need and qualify for therapeutic community treatment. This bill would provide financing for 60 new corrections beds in Valdez and, thus would help ease the pressure on a severely overcrowded correctional system. This legislation also keeps with art. I, sec. 12, of the Alaska Constitution, which mandates criminal administration be based on the principle of

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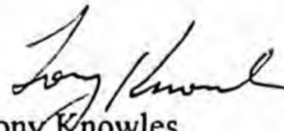
reformation. Anticipated costs for fiscal year 1999 would be approximately $2.5 million, of which $569,000 is planned for treatment. Annual costs thereafter are estimated at $2.7 million.

This bill is one more step the state can take to reduce the number of victims of crimes resulting from an offender's substance abuse, provide intensive treatment to reduce repeat criminal behavior, and provide new beds for a severely overcrowded correctional system.

I urge your quick and favorable action so the Department of Corrections can begin occupancy by September, 1998.

Sincerely,



Tony Knowles
Governor

Alaska State Legislature

Senate

JERRY WARD

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Memorandum

To: Senator Bert Sharp
Senator Drue Pearce
Co-chairs Senate Finance Committee

From: Senator Jerry Ward
Chair Senate Finance Subcommittee on Corrections

Date: March 2, 1998

Re: Harborview Treatment Center

I hope to attend today's hearing concerning the Department of Corrections proposed re-use of the Harborview Hospital facilities in Valdez, but I may be late or unable to attend due to a previously scheduled conflict. I would appreciate it if my concerns and observations could be read into the record and discussed, as the chair deems appropriate.

As Chair of the Senate Finance Subcommittee on Corrections, my concerns are not directed toward the merit of filling the economic void left by the Governor's decision to close the Harborview Hospital or the clear and present need for substance abuse treatment among the majority of Alaska's inmates. My concerns question whether funding a small, isolated, "therapeutic community" is the highest and best use of correctional resources at a time when our prisons and jails are faced with the worst overcrowding in state history.

I need not remind the Finance Committee that the Department of Correction's operating budget is the fastest growing budget among state agencies. On the Corrections Subcommittee, we have worked diligently to maximize the cost/benefit of corrections spending. Revenue enhancement, program efficiency and economies-of-scale are but a few of the methods that we have employed to hold the line on corrections spending. The Harborview proposal doesn't simply fail the wise stewardship test, it bears no rational relationship to the commitment we have made to reduce unnecessary spending and increase government efficiency.

At the daily operating rate of $124.37 per inmate per bed, the Harborview proposal ranks as the third highest bed rate in Alaska. Only Bethel and Ketchikan slightly edge out Harborview as the costliest correctional services in the state. Indeed, when custody is considered, these are the most expensive low custody beds in the nation. If these inmates are indeed low custody, wouldn't it be wiser to establish a therapeutic "pre-release" community in an existing halfway house at two-thirds to one-half the cost?

Again, I do not dispute the need for this type of program for Alaska's felony inmate population. These programs however must be funded in the context of our higher need for safe and secure prisons and jails.

There can be no question that corrections can achieve a significaly better bang for it's treatment dollar by developing programs at sites that are closer to professional treatment resources and which provide greater economies-of-scale. The formula we apply in the subcommittee is "the greatest service for the highest number of offenders at the lowest cost, without unreasonable reduction of quality." The Harborview proposal fails this test.

Corrections has several sites which house hundreds of low custody prisons. There is no reason that a "therapeutic community" cannot be established within the confines and programmatic structure of an existing correctional facility or halfway house. Indeed, the Palmer Correctional Center at Sutton was the preferred site for this program in the last administration. That plan was scraped in this administration for reasons that appear to have little to do with sound correctional practice. Indeed, the economies-of-scale, extra ordinary facilities and lower cost of the proposed Fort Greely prison makes more sense than the Harborview proposal.

If the Legislature chooses to fund this program let's call it what it is: a gratuitous government handout to the City of Valdez. There are, at times, sound public policy reasons for such government subsidies. And this may be one of those times, but lets not fool ourselves into believing this proposal is the wisest use of correctional resources or is, as the Commissioner so often says, "sound correctional practice."

Thank you for your attention and consideration.

cc: Senate Finance

January 22, 1998

JOHN K. BODICK
Assistant Attorney General
310 K. Street, #308
Anchorage, Alaska 99501

Re: CACM Evaluation of Model and Plan Filed December 22, 1997

Dear John:

As you are aware, Judge Hunt has calendared a status conference for February 4, 1998 at 1:30 p.m. You, Allen Cooper, Chris Lyou and I discussed the Department's Plan to control crowding while in Arizona last week, and at that time you indicated it would be helpful for the CACM to provide a written summary of major concerns prior to the status conference. I set forth those issues below. This letter is for your evaluation. It will not be distributed to the plaintiffs or the public. I have attempted to be as forthright and brief as possible.

To begin, it is important to place the CACM's findings in context. My role is to assist the Court and the parties in resolving Alaska's jail and prison crowding, and to work towards the end of court monitoring of the DOC. Therefore, I want the efforts of *this administration* to be successful. Unfortunately, at this point in time crowding is approaching crisis levels and the failure to develop a workable population plan may have irrevocable consequences.

The Plan "Overview" and Sections I and II are well written and accurate. This portion of the Department's filing reflects the serious attention which was devoted to the project by DOC Superintendents and Central Office personnel. In addition, Section III, up to item F on page 15 sets forth a number of practical steps to reduce hard bed use by expanding community alternatives. Commissioner Pugh and her staff deserve credit for this important effort.

However, the Plan, beginning on page 15 and continuing through page 18 is inadequate and does not comply with the Court's orders of August 15, 1997. The major shortfalls can be summarized as follows:

1. The Plan is not a "plan." It represent yet another "plan for a plan," the very practice criticized in the CACM's July 1997 Report, criticized by prior OACMs, and criticized by the Court. It leaves unanswered the most important question.

2. Defendants' submission is also not accurate. Options F, G and H were rejected, for good reason, by the Population Group. The inclusion of these options in the Plan is inappropriate for the following reasons:

A. "Contract Jails" are unsuitable for long term housing, many are already overcrowded, and some operate with deplorable conditions. This option represents a potential major extension of the scope of Cleary, and will lead to the CACM inspecting the contract facilities in 1998.

B. According to the Population Group, expanding Point McKenzie will not lead to a reduction of hard beds unless sex offenders will be placed at that facility, a change in policy which presents a serious risk to the public. Furthermore, it was agreed that the plan would be implemented in six months in order to respond to the Court's orders [May, 1998, the low point in the Department's cyclical population]. The twenty beds which may be added at Point McKenzie will not be on-line by May, 1998.

C. During its meetings, the Population Group considered a recommendation to expand the Valdez Therapeutic Community. Betsy Robson made a presentation to the Group and urged that this option be

rejected because the Valdez project does not contemplate removing prisoners from hard beds. Valdez does not provide for any short term reduction in hard bed use. In addition, the Group was informed that funding was questionable, and that even if funding became available, the Valdez beds will not available by the May, 1998 target date.

Overall, the use of these options F, G, and H in the Plan, after they were rejected by the Population Group, serves to distort the scope of the existing crisis. Assuming that options A through E actually work, the Department needs at least 260 hard beds, not 180 [option J on page 16 is therefore misleading]. The public and the legislature need to hear accurate information, and the Plan is not accurate.

Despite these shortfalls, the CACM believes it appropriate to commence another effort to work with the Department to develop a real plan. Our meeting in chambers will perhaps be more productive and candid that one in open court, and will avoid the embarrassment of a public report and public hearing. To achieve the maximum benefit from this meeting, the CACM requests that defendants consider the following:

1. Exactly what information will be submitted in the proposed March 20, 1998 filing? Why should the Court delay imposing additional sanctions until March 20, 1998?

2. Who, other than the Department of Corrections, should take the leadership concerning overcrowding? Despite the politics, doesn't the Department have an obligation to place partisan opinions to one side, at least in terms of effectuating a dialogue which may resolve the current crisis? If the named defendants cannot set forth a real plan and crowding continues, shouldn't this responsibility default to another agency? Given the current population crisis and the history of the Department's failure to implement an adequate plan to control crowding, what reason is there to wait another year before the default takes place?

3. Complying with the Court's orders does not always appear to be the highest priority among certain Central Office personnel. If defendants believe that other issues are more important that complying with the Cleary mandates, those issues should be brought forward. Some efforts which were advertised as having an impact on crowding, e.g. Valdez and the Criminal Justice Assessment Commission, have not demonstrated the ability to reduce hard beds at any time in the foreseeable future. Should these projects continue while the hard bed institutions collapse? Shouldn't defendants prioritize, during 1998, their limited resources and devote adequate resources to control crowding, even if less important programs and conferences are curtailed?

4. The CACM is convinced that the public and the legislature are confused about the nature of the monetary sanctions and the responsibility for those sanctions. Sanctions are calculated based upon the number of bed/days over the emergency cap, however the *only* cause for the issuance of sanctions has been the Department's continued failure to implement a real plan. This must be, and *it will be* explained to the public during 1998. As just one example, the Department's failure to create a plan in response to the Court's August 15, 1997 orders cost the Alaskan tax payers $135,900.00 in December 1997, funds which could have instead been utilized to address criminal justice issues.

On the other hand, if the Department had a real plan, perhaps the monetary sanctions previously incurred could be utilized as a tool by the Department to convince other agencies to implement an Alaskan program to control crowding. Can the CACM and the Court assist with this effort?

John, if you want to discuss these issues prior to the status conference, or if your clients believe a direct line of communication would be helpful, do not hesitate to call.

Sincerely yours,

John Hagar
Compliance Monitor

c.c. Allen Cooper
J. Christian Lyou

STATE OF ALASKA

DEPARTMENT OF CORRECTIONS

TONY KNOWLES, GOVERNOR

REPLY TO:

PO BOX 112000
JUNEAU, ALASKA 99811-2000
PHONE (907) 465-3376

January 22, 1998

Representative Jeanette James, Chair
House State Affairs Committee
State Capitol, Room 102
Juneau, Alaska 99801

Dear Representative James:

I respectfully request a hearing on House Bill 329, "An Act amending the definition of correctional facility to include a therapeutic center..."

The Department of Corrections is excited about the possibility of operating an in-prison intensive substance abuse program, often referred to as a Therapeutic Community or treatment center. This model of substance abuse treatment has recently been evaluated and shows a consistent reduction in recidivism rates for inmates who are chronic substance abusers.

This legislation would amend the definition of "correctional facility" to include a therapeutic treatment center. In addition it would require conveyance of the title to the Harborview Developmental Center in Valdez to the City of Valdez. And finally, sets out conditions that are required in order for the conveyance to take place.

The Department of Corrections has planned for a sixty-bed treatment center in the Valdez facility. Based on other experiences from around the country, I believe this would be a positive step towards reducing the recidivism rate, and more importantly reducing the number of victims of substance abuse related crime. The current plan includes an evaluation component that will be in place before the first inmate enters treatment. It will encompass process information as well as outcome data.

I have attached materials that I believe will be helpful to members of your committee when considering this legislation for approval.

Thank you for your consideration.

Sincerely,

Margaret M. Pugh

Margaret M. Pugh

CC: Pat Pourchot, Legislative Director
Office of the Governor

Attachments

Yes!

Anch. 269-7410 Sec'y / Call to testify!
1407 direct
Betsy Robson
DOC - Corrections
465-4652 (wants to testify on Harborview Bill)
(by teleconference)

printed on recycled paper by C.D.

To: Ms. Sarah Williams Company: Alaska Dept of Corrections Fax: 907-269-7420

CSAT by Fax

January 14, 1998
Vol. 3, Issue 1

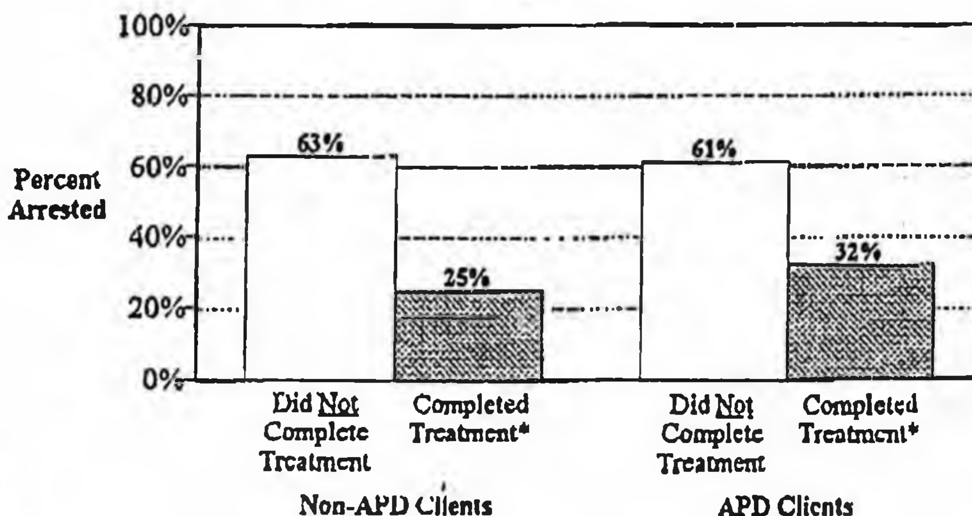
A Special Edition of CESAR FAX

A Collaborative Effort of the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Research (CESAR)/University of Maryland

Study Finds Therapeutic Community Reduces Drug Use and Criminal Activity Among Substance Abusers With Antisocial Personality Disorders

While there has been limited research on the treatment outcomes of clients diagnosed with antisocial personality disorder (APD), it has been widely accepted that APD clients would not benefit from substance abuse treatment. However, a CSAT-funded experiment found that clients with APD were as likely to complete therapeutic community (TC) treatment as non-APD clients. In addition, APD clients who completed treatment exhibited the same patterns of reduced drug use and criminal activity as did non-APD clients. The authors suggest that efforts "be made to attract and retain the more behaviorally deviant persons into TC treatment" (p. 14).

Post-Discharge Arrest of Therapeutic Community Treatment Clients, by Treatment Completion and Antisocial Personality Disorder (APD) Diagnosis
(N-338)



*Completed both the inpatient and outpatient phases of treatment.

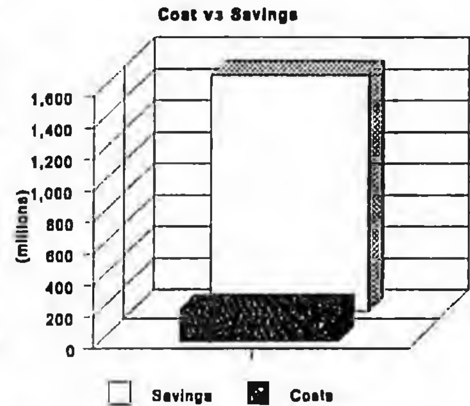
SOURCE: Adapted by CESAR from Nena Messina, Eric Wish, and Susanna Nemes, *The Efficacy of Therapeutic Community Treatment for Substance Abusers with Co-Occurring Antisocial Personality Disorders*, paper presented at the Annual Meeting of the American Society of Criminology, San Diego, CA, November 22, 1997. For more information, contact Eric Wish at 301-403-8329.

CSAT by Fax is supported by funding from CSAT, Substance Abuse and Mental Health Services Administration, and may be copied without permission with appropriate citation. For mailing list modifications contact CESAR at •• 301-403-8329 (voice) •• 301-403-8342 (fax) •• CESAR@cesar.umd.edu •• www.bsos.umd.edu/cesar/cesar.html ••

Reducing Crime Through Prevention: Attacking Hardcore Substance Abuse

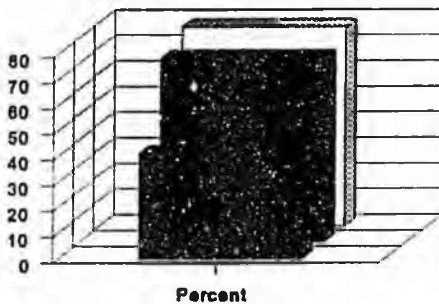
The Need in Alaska

One of the few universally accepted propositions relating to the commission of crime in the United States is that offenders are disproportionately substance abusers. In Alaska it is estimated that between 80% - 90% of the inmates in our institutions have some involvement with substance abuse. Programs throughout the U. S. have demonstrated that substance abuse treatment can reduce the rate of recidivism and ultimately impact the cost to government. The Alaska Department of Corrections proposes to operate a prison-based therapeutic treatment program for inmates who have histories of serious substance abuse.



A Sound Investment

In 1994 Governor Pete Wilson of California directed the most rigorous, retrospective outcome study ever-conducted on drug abuse treatment. There were three major conclusions: First, treatment is very cost-beneficial to taxpayers. The cost benefit averaged a $7 return for every $1 invested. In 1992, the cost of treating approximately 150,000 individuals was $200 million. But benefits gained during treatment and in the first year afterward totaled about $1.5 billion in savings. Second, criminal activities significantly declined after treatment. And third, significant improvements in health and corresponding reductions in hospitalizations were found during and after treatment.



Treatment Works

Studies conducted on programs in Delaware and New York found evidence of significant success; Alaska's proposed treatment design is similar to that used in these two programs. Clearly, any increase in the number of treated offenders staying arrest-free would have a positive effect on both the criminal justice system and the overall welfare of Alaska's communities.

The Cost of Doing Nothing

Chronic users of both alcohol and drugs tend to lose their ability to resist these substances, and many eventually engage in self-destructive and criminal behavior under their influence. The public's increasingly low level of tolerance for such behavior in recent years has resulted in longer and stronger levels of incarceration for criminal offenders. In turn, prison populations and the associated costs to the public have grown phenomenally, and will continue to do so if nothing is done. Treatment programs for chronic abusers bear the potential to reverse this trend; they will help not just the prisoners themselves, but also will reduce the financial consequences of substance abuse underwritten by the rest of society, as well.

Valdez Therapeutic Community

The Alaska DOC offers 3 types of Inmate Substance Abuse Programs in its correctional facilities: substance abuse education, education plus an introduction to treatment, and institutional outpatient treatment. There are a substantial number of inmates who need and qualify for a therapeutic community treatment modality. There are only 4 DOC treatment beds in the community reserved for DOC furloughees who need this intensive type of treatment. DOC needs to complete its continuum of care by offering this modality to inmates.

The DOC inmate population is 118% of its emergency capacity. Inmates who complete treatment in the Valdez Therapeutic Community will enhance their opportunities for parole or furlough, thus eliminating their need for prison beds. In Alaska a significant number of the probation/parole violations involve relapse into substance abuse. If inmates receive the level of treatment they need while incarcerated, their chances of being successful in the community are increased. They are less likely to suffer relapse in the community and become repeat offenders.

Residential Substance Abuse Treatment for State Prisoners (RSAT), under the U.S. Department of Justice, reports in 1997 that recent research and evaluations show consistent reductions in recidivism rates for offenders completing in-prison substance abuse treatment programs. "Successful outcomes are tied to the length of time in treatment (at least 6 months) and continued treatment in the community after release. Programs that address the myriad problems associated with the life-style of drug use and addiction are the most effective."

How will the Valdez Therapeutic Community be different from other DOC Inmate Substance Abuse Programs?

The Valdez Therapeutic Community will be isolated from the general inmate population so that the inmate culture will not prevail. Individuals completing the TC will not rejoin the general inmate population.

Preparation for transition into the community will be thorough.

Progression through intensive treatment phases will teach responsibility.

Day-to-day behavior will be magnified in order to break criminal thinking errors.

Cultural relevance for Alaska Natives will be a predominant treatment theme.

Evaluation Plan for the Valdez Therapeutic Community:

The Alaska DOC has secured a technical assistance grant from Residential Substance Abuse Treatment (RSAT), under the auspices of the U.S. Department of Justice, for planning the evaluation component for the Valdez Therapeutic Community. The evaluation component will be in place before the first inmate enters treatment. It will encompass process information as well as outcome data. The evaluation component will assist DOC and the contract treatment provider in making program improvements as well as measuring the criminal recidivism rate of inmates completing the program.

National Findings Regarding Therapeutic Communities:

According to the Office of National Drug Control Policy, February 1995, "Studies and statistics indicate that the fastest and most cost-effective way to reduce the demand for illicit drugs is to treat chronic, hardcore drug users. Without treatment, chronic hardcore users continue to use drugs and engage in criminal activity, and when arrested, they too frequently continue their addiction upon release. The cycle of dependency must be broken and the revolving door of criminal justice brought to a halt."

Therapeutic communities represent a rehabilitation response to people to whose antisocial behavior has resulted in significant and chronic problems, most often with the criminal justice system. Rates of recovery for those residents who remain in therapeutic communities beyond the first six weeks are surprisingly high. (Please see attached CSAT news brief.)

In March 1996 the Office of National Drug Control Policy reported that more than one third of all admissions to therapeutic communities demonstrate long-term successful outcomes one to two years after treatment.

A major study of the Stay'n Out therapeutic community located at two New York prisons established that prison-based treatment based on a therapeutic community model can result in significant reductions in recidivism rates. (Falkin et al., 1991; Wexler et al., 1990)

In a study conducted on the Cornerstone Program in Oregon it was determined that 37 percent of Cornerstone graduates had no arrests, 51 percent had no convictions, and 37 percent had no time in prison. (Field, 1989)

The Key-Crest Program, a prison-based therapeutic community established in Delaware reports 73 percent of the inmates completing the program remained arrest free for a minimum of 18 months after release. The graduates of the program are three times more likely to remain drug-free than those who do not participate in treatment. (March, 1997)

The new Vision In-Prison Therapeutic Community for men, located in Kyle, Texas, treats 500 inmates. It was found that one-year after release only 7 percent of those completing the program had returned to prison. (Keeping score 1996, Drug strategies 1996)

California Program Reduces Recidivism and Saves Tax Dollars

by Rod Mullen, John Ratelle, Elaine Abraham and Jody Boyle

In the spring of 1989, Warden John Ratelle of the Richard J. Donovan Correctional Facility (RJD) received a call from then-director of the California Department of Corrections (CDC), James Rowland. "John," the director said, "It's time that the department begins to do more about substance abuse in the inmate population. Most of our inmates have drug problems, and they are the majority of our returns to custody. Would you be willing to have a drug treatment program at your facility that we could use as a model?" Ratelle, who had opened RJD three years ago, said he would be willing to open a drug treatment program at his prison, which is near San Diego, just a mile from the Mexican border. "But," he recalls saying, "I told the director that I wanted to look at some programs before I made a final decision and that, if we went forward, I wanted to be able to close the program immediately if I felt it was not working."

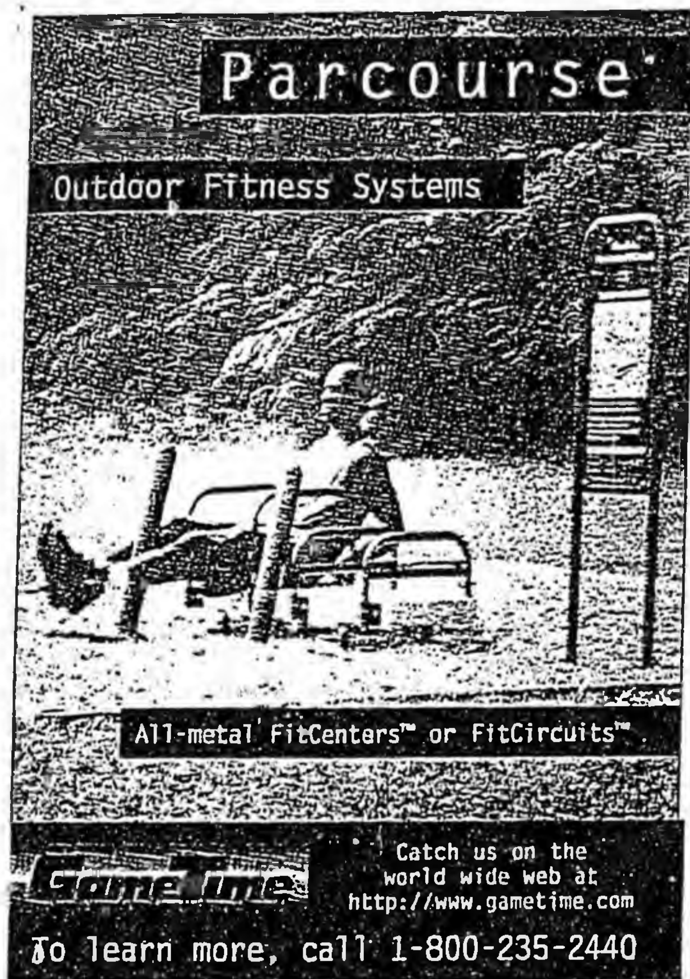
Participants at the Amity Program in Vista, Calif., learn to take responsibility for their own actions.

Rowland asked Ratelle and Chief Deputy Tom Hornung to visit the Amity/Pima County Jail Program, a national demonstration program funded by the Bureau of Justice Assistance at the Pima County Adult Detention Facility in Tucson, Ariz. Rod Mullen, president of the Amity Foundation of California, gave them a tour of the jail pod where 50 sentenced drug offenders engaged in a therapeutic community-type program using ex-addict counselors, a specific curriculum developed by Amity, and a well-developed program of cross-training between correctional officers and treatment staff. An evaluation of the Amity program showed excellent results in lowering recidivism to drugs and crime after inmates left the program.

Ratelle admits that he came to look at the Amity program with a great deal of skepticism. "I've seen a lot of programs come and go, and a lot of them have been games where inmates lay around all day, continue to use drugs, go to meetings occasionally, manipulate untrained correctional counselors, get their day-for-day credit—and then got out and go back to drugs and crime." When he talked to inmates in the Amity program, he met some who had done time in the California system. They talked about how the Amity program was different. He observed encounter groups and saw that the program was dealing with real issues, not allowing inmates to shift the blame for their mistakes to others, but making them take personal responsibility for their own behavior.

"I've known some of these guys [inmates] for 30 years," Ratelle says. "Because of their addiction, they are doing life on the installment plan. Prison has become a way of life, and they are comfortable here. We needed something to get their attention, shake them up, and get them to change."

Continued on page 120



MODEL CALIFORNIA PROGRAM

Continued from page 118

Ratelle's willingness to "take a risk" led to a collaboration between the CDC and AMITY, a private nonprofit organization that specializes in programs for drug-involved offenders. An independent five-year study of the Amity program funded by the National Institute on Drug Abuse shows that, to date, 63 percent of those receiving no treatment were reincarcerated a year after release, but less than half (46.2 percent) of those who completed the Amity in-prison program were reincarcerated, and just over one-fourth (26.2 percent) of those who completed the in-prison program and then went on to the Amity residential program in Vista, Calif., were reincarcerated. The study is not completed yet, but researchers believe that the final outcomes will be very close to what is reported here.

The Amity program began at RJD in the fall of 1990. Ratelle dedicated building 15 in yard three of his 4,600-man institution to the treatment program—with 200 inmates, three correctional counselors and two double-wide trailers constructed for program space. Mullen and Amity's Deputy Director Naya Arbiter selected staff from Amity's Tucson programs, mostly ex-addicts, some who were ex-offenders, and put them through an intensive training program. The treatment staff worked closely with correctional counselors and classification staff to select inmates. By late December 1990, the program was functioning; by March, all 200 inmates were in the housing unit, and the trailers (for program space) were operational.

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Facts About the California Department of Corrections

1. In 1980, CDC had a commitment population of 22,500.
2. Projections indicate the institutional population will increase to 172,694 by June 1998, 219,795 by June 2001, and 340,000 by June 2006.
3. These increases are driven by parole violators and inmates who have longer sentences because of "three strikes" legislation.
4. CDC institutions are at 183.1 percent over design capacity, and without new construction, CDC will run out of space for new inmates in 1998.
5. The average sentence is 43 months; average time served, 21.3 months.
6. The racial breakdown of inmates is 34 percent Hispanic, 31.5 percent African-American, 29.6 percent Caucasian, 4.9 percent other.
7. A breakdown in offenses shows 41.8 percent violent, 25.3 percent property, 26.4 percent drugs, 6.6 percent other.
8. A recent CDC survey shows that 75 percent of committed offenders have histories of drug abuse.
9. In 1984, 9.3 percent of inmates were committed for drug offenses (sales, use and possession). At the end of 1995, drug offenders accounted for 31.9 percent of all new admissions to CDC—the largest offense category of new felon admissions.

"One of the most important things was the relationship that I had with Elaine Abraham, Amity's program director," Ratelle says. "Right away it was 'we' not 'us' and 'them.' She impressed me. She held the line with the inmates, and did not allow them to manipulate her or the program." After a year, Ratelle sat in on an encounter group with several inmates, including a couple of "old timers" who he had known for 20 years or more. They were "baring their souls" about their personal histories in a manner that impressed Ratelle. "I could tell that we had gotten to these guys," he says. "I knew that they would never have broken the convict code otherwise."

Ratelle decided in 1992 to do a surprise urine drop of the entire Amity in-prison program—to see if "it was really working." He told no one of his decision, neither his staff nor the Amity program staff. On a Monday, after weekend visitation, he locked down the entire housing unit where the Amity inmates are housed. Each inmate was asked to give a urine specimen. "I knew that I had 200 guys with serious drug problems all living together and not isolated from the main yard. We were busting guys on the yard for drugs, so I knew that if the guys in Amity wanted to get drugs, they could. I assumed that 25 percent of the people in the Amity program would turn up 'dirty.' Only one Amity participant tested positive for drugs—marijuana."

"The key," adds Mullen, "was that the warden waited two years before the 'surprise'—that gave us time to get the program working. He didn't do the test in the first year, while we were still wrestling with implementation and program integrity."

Have there been any problems in implementing the program? Ratelle explains, "There really has been no downside to the Amity program during the past six years—the inmates in the Amity program work like other inmates in institutional support jobs and get their day-for-day credit; the housing unit they are in has less disciplinary reports than any of the other units on the yard, and less grievances, too. There has been no violence—just a few scuffles—in six years. And the outcome data shows that these guys are coming back at a significantly reduced rate compared with inmates who did not go through the program."

The program fits in with Ratelle's philosophy. "You don't run an institution with guns, you run it with your mouth—you run it by communicating—and 80 percent of communication is listening. We have an excellent staff here at RJD—and they keep getting better every year. The Amity staff and program have become part of us and have grown with us."

What are the incentives for inmates to participate in the Amity program? "The participants in the Amity program,"

Continued next page

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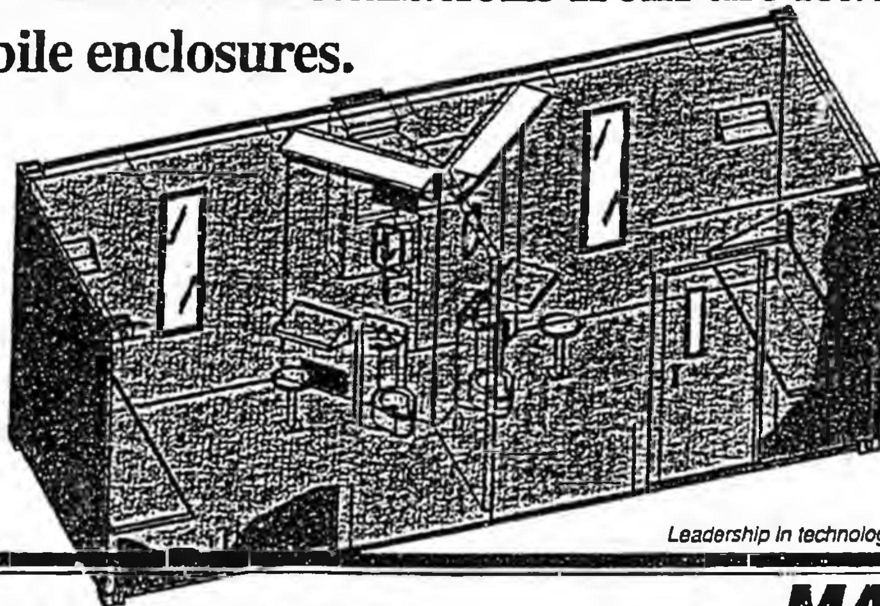

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says Director Elaine Abraham, "have a harder time than other inmates—they have to work every day to get their day-for-day credit, they have to participate in our intensive treatment program in what would be their spare time, and they submit to more urine drops than other inmates. They are under a microscope from staff and peers about their behavior, we push them very hard emotionally, they are not eligible for work furlough—and we expect them to stay clean, continue treatment, get jobs and support their families when they leave. We have a lot of credibility among inmates because no one gets anything in terms of reducing their sentences or any special privileges for participating in the program. The reward is the opportunity to stop being on the revolving door in and out of prison. Still, we get hundreds of applications a month for the few program spaces we have open—and that says a lot." she says.

Who is in the Amity program? Ratelle says, "Amity has the typical career criminal you would find in any level three or four CDC institution. There are few first termers, but the inmates in the program are not the cream of the crop. In fact, 51 percent of Amity participants have two strikes—if they go out and re-offend, they are going to do 25 [years] to life."

The profile of the inmates in the Amity program reveals that they have an average of 27 lifetime arrests and have been incarcerated 17 times for an average lifetime incarceration of more than six years. Many were involved with gangs on the streets, but both CDC and Amity demand that gang ties be severed in order to participate in the program.

"We've worked very hard to keep the program ethnically balanced," Mullen says. "In order to do this, we asked the warden to extend the length of the program, since Hispanic inmates usually were doing longer sentences and many weren't eligible for the program. Ratelle felt as strongly as we did that the program needed to match the ethnic balance of the CDC institutional population as closely as possible so that the program did not get identified as a 'white program,' a 'black program' or a 'Chicano program.' "

Mullen says one of the unsung heroes of our success is Jody Boyle, the parole agent who has been assigned to the program from its inception. She's been the catalyst for networking parolees from Amity together to support each other. Boyle says AMITY is different than other programs. The men become very close and form relationships with each other in the prison that they maintain on the streets," she says. "I see a lot of these guys still close friends and still helping each other several years after they are out of prison."

California DOC Director James Gomez says, "I think that one of the most important aspects of the CDC/Amity collab-

Elements of Success

The following are the elements of success for the Amity program that CDC administration, and institutional, treatment and parole staff see as critical:

- a director of corrections who saw the economic impact of drug abuse on the correctional budget (and public safety) and was willing to break new ground in addressing these issues;
- central office staff who worked closely and effectively with the institution, parole, treatment staff in the prison, and the treatment program in the community;
- a warden who was willing to take a risk and maintained a hands-on relationship with the program—insisting on fitting the program to the institution, but also treating the treatment staff with respect and giving them the independence needed to carry out their jobs;
- the buy-in of the correctional staff in the institution to support the new program
- a correctional facility that was well managed and stable:
- a treatment program that was experienced in working with offenders and committed to a joint-venture/collaborative approach to corrections;
- a curriculum specifically designed for the inmate population served that was based on "emotional literacy" and issues particularly relevant to inmates in the program, including substance abuse, family dynamics, violence, racial prejudice, relapse prevention, moral development, building and maintaining positive relationships, and "how to get prison out of you";
- a treatment program director who was willing and able to work cooperatively with the institution in implementing the program and maintaining it;
- a treatment staff that was able to work side by side with the institution and maintain credibility to the inmates;
- the incorporation of "lifers" into the Amity in-prison program as credible role models and trainees;
- regular cross-training of treatment, correctional and parole staff together to enhance understanding, cooperation, communication and a sense of joint ownership;
- the assignment of a parole agent who worked in an integral fashion with corrections and treatment staff and was the catalyst for supporting parolee program completers in the community; and
- the development of a "linked" aftercare program for Amity prison inmate completers that allowed a true continuance of treatment in the community.

oration was the confidence that it gave the Legislature and the governor to authorize over $100 million to build the largest dedicated prison drug treatment program in the world. And, it gives us at CDC the confidence that it could and should be done. The Corcoran II Substance Abuse Treatment Facility will house more than 1,400 offenders beginning in 1997—and it could have come about only through Amity's work. It is clear that Amity's program results are going to help shift the public debate about corrections here in California to a more treatment-oriented approach. We have to continue to respond to the public demand to take violent offenders off the streets, but we also have to make sure that we use a targeted approach and don't lump all our inmates into the same category."

As part of a restructuring six months ago, Amity transferred the administration of the program to the National Development and Research Institutes Inc. (NDRI) for calendar year 1996, keeping the same staff and curriculum in place. NDRI has been responsible for the independent evaluation of the Amity at R. J. Donovan Program during the past five years.

A recent cost-benefit analysis prepared by CDC's Office of Substance Abuse Programs at the direction of the California legislature used an "avoided cost model." Assuming that the Amity outcomes could be replicated, the analysis estimated that a 200-bed program like RJD would, by reducing returns to custody, save CDC about $7.5 million over seven years (above the cost of the treatment program itself)—more than $1 million per year.

For a 3,000-bed program, the seven-year estimated savings would be $29,705,000. These savings do not take into account the "on-the-streets" savings of Amity graduates who become employed, pay taxes, reunite with their families, get off welfare and join other Americans in shouldering their share of social responsibility. At a time when public debate is honing in on how to make government more efficient, the results of the Amity/CDC collaboration look very good indeed.

Program Description

- Two hundred men live in a housing unit on a yard with 800 other inmates. Amity participants share the yard with the rest of the inmates, but program space is isolated.
- Twenty Amity staff, mostly ex-addicts and ex-offenders trained by Amity to work in prison participate in CDC security training for correctional officers to receive their security clearance. All participate in a minimum of 40 hours per year of Amity immersion training to keep skills current.
- Six "lifers" (life with possibility of parole inmates) work with Amity staff as credible role models and help stabilize the program.
- Forty program participants (inmates) work one week on, one week off, supporting staff in delivering the Amity program.
- The Amity curriculum was developed more than 15 years ago by Naya Arbiter. A written and videotaped curriculum specifically designed to reach habitual offenders with chronic drug abuse histories, the curriculum involves encounter groups, seminars, video playback, psychodrama, and written and oral exercises. It addresses violence, family dynamics, gang involvement and other issues relevant to this population.
- A therapeutic community approach demands a very high degree of accountability from participants and staff.
- A Correctional Counselor III and two Correctional Counselor staff members work with Amity staff and institutional staff to select inmates, conduct disciplinary proceedings, develop treatment plans and develop discharge plans.

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Societal Outcomes & Cost Savings of Drug & Alcohol Treatment in the State of Oregon

Prepared for
Office of Alcohol and Drug Abuse Programs
Oregon Department of Human Resources
and
Governor's Council on Alcohol and Drug Abuse Programs

by Michael Finigan, Ph.D.

February 1996

"Societal Outcomes and Cost Savings of Drug and Alcohol Treatment in the State of Oregon" is a study researched and prepared by

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EXECUTIVE SUMMARY

Cost Savings/Societal Outcomes of
Drug and Alcohol Treatment in the State of Oregon

- This study was designed to overcome some of the methodological limitations of past studies of the benefits and costs of drug and/or alcohol treatment. To this end the research design has been created with the following characteristics:
    - A representative sample of treatment completers with a matched comparison group of clients who received little or no treatment
    - Use of existing state agency databases rather than self-report data for maximum objectivity
    - Adequate study period of two years prior and three years subsequent to treatment completion
- With no statistically significant differences in arrest and conviction histories prior to treatment, treatment completers had significantly fewer arrests and convictions in the three year period following treatment. For example, outpatient treatment completers were arrested at a rate 45% lower than the matched group during the three year period subsequent to treatment.
- Treatment completion is associated with substantially fewer incarcerations in the state prison system and with fewer days of incarceration. For example, residential treatment completers were incarcerated at a rate of 70% lower than the matched group.
- In the period subsequent to treatment, treatment completers received 65% higher wages than those who didn't complete treatment. This difference is due to improvement in earning power and in number of weeks worked.
- The use of food stamps was reduced significantly for clients who completed treatment compared with those who were non-completers. Completers had only one-third the use of food stamps experienced by the early-leaver comparison group.
- For clients who completed treatment, open child welfare cases decreased by 50% subsequent to treatment.
- Medical expenses were substantially lower for those who completed treatment compared with the control group. For example, early-leavers showed a dramatic increase in the use of hospital emergency rooms during the period following

treatment compared with the treatment group.

- The 1991–92 cohort of treatment completers produced cost savings of $83,147,187 for the two and a half years following treatment. The cost for treating all adults in 1991–92 was $14,879,128. Thus, every tax dollar spent on treatment produced $5.60 in avoided costs to the taxpayer. This is most conservative for the following reasons:

    - No unemployment cost savings are included.
    - We can assume some benefit accrued to those clients treated for weeks and/or months but who did not complete treatment. These savings are not included in this study.
    - There are other potential cost avoidances not included in this study, e.g., federal and local prison costs saved, institutional costs avoided, intoxicated driver costs avoided, business losses avoided, healthy rather than drug-affected babies born, etc.

- The accrual of positive societal outcomes resulting from alcohol and drug treatment were found to be significant for a period of at least three years.

In the summer of 1994, the Office of Alcohol and Drug Abuse Programs and the Governor's Council on Alcohol and Drug Abuse Programs requested an independent study of treatment outcomes for drug and/or alcohol treatment clients in publicly funded residential, outpatient, and methadone settings. Included in that request was a desire to augment the research with an assessment of the savings that might accrue (or cost that would be avoided) to Oregon taxpaying citizens from any positive outcomes of treatment. Because this assessment would be limited to the avoided costs that are measurable using existing Oregon state agency databases, it would be only a conservative estimation.

Over the past 30 years there have been a number of studies involving economic analyses of the benefits and costs of drug and/or alcohol treatment.[1] The usefulness of their results has often been weakened by limitations in their methodologies. These limitations include the following:

- No comparison or control group
- Failure to use a representative sampling design in selecting subjects
- Exclusive use of self-reported data
- Brief observation periods (usually focused on the time just before or just after treatment—not necessarily representative periods)
- Use of limited populations (e.g., enrollees in an HMO)
- Costs and benefits assessed only in a limited number of areas

Several studies of the costs and benefits of alcohol and drug abuse treatment have recently been conducted and have received national attention. The most notable include a national study by the Center for Substance Abuse Prevention—*Costs of Alcohol-Connected Crime* (1995) and the CALDATA study (1994).[2] The CSAP study is useful in that it provides some cost estimates of alcohol-related crime specific for Oregon; however, it is not a study of the outcomes of treatment. The CALDATA study is one of the largest studies ever attempted that combines a study of treatment outcomes with an estimate of the cost savings of treatment. The researchers selected a

---

[1]For a thorough examination of all but the most recent research, the reader is referred to *Socioeconomic Evaluations of Addiction Treatment* prepared by the Center of Alcohol Studies at Rutgers University.

[2]CSAP Prevention Monograph *Costs of Alcohol-Connected Violent* Crime, 1995; Dean Gerstein, et. al. "Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment," Report to State of California Department of Alcohol and Drug Programs, (April 1994), 63.

representative sample of discharged clients from substance abuse treatment programs (outpatient, residential, and methadone) statewide. They located 1826 clients who agreed to complete a retrospective interview that included questions about criminal and medical issues, substance use, income, and other concerns for the period 12 months before and after treatment. The study received national attention with its conclusion that for every dollar spent in treatment, seven dollars were saved in avoided costs to society. The study has had its critics who have accurately noted its methodological limitations. These include the following:

- The study relied primarily on retrospective self-reported data from clients who were required to remember the occurrence of events up to 36 months after they occurred.
- The observation time period was very brief. The period of 12 months before and after treatment is not necessarily representative of the before treatment and after treatment periods.
- The study used a pre–post design and had no comparison group.
- The subjects of the study were clients who had been discharged, not necessarily clients who had completed treatment.

This Oregon study has been designed to avoid (where possible) the methodological problems that have plagued previous studies. To this end the research design has been created with the following characteristics:

- Representative sampling of treatment completers
- Development of a matched comparison group using clients who enrolled in treatment but left before receiving an appreciable amount of treatment
- Use of existing Oregon state agency databases rather than self-reported data
- A time period of two years prior and three years subsequent to treatment completion

METHOD

Using a quasi-experimental design, groups of clients who completed treatment were compared with groups of clients who had enrolled in treatment programs, but who terminated after receiving only minimal services. The sample was drawn from the 1991–1992 fiscal year in order to have up to three years of post-treatment outcome data. Using the Client Process Monitoring System (CPMS) database[3], a representative random sample of clients for each service element (outpatient,

---

[3] This database is the Oregon management information system for alcohol and/or drug treatment programs receiving public funds. Programs must report on clients at intake and at termination.

residential, and methadone[4]) was selected. A comparison group of those who began treatment but did not follow through in keeping appointments was randomly selected and matched to the treatment completers so that no differences existed between the groups on age, gender, race, drug type, and severity of drug abuse. Based on a power analysis of needed sample size, a target of 250 treatment and 250 comparison clients was set for each module, outpatient and residential. A total of 1267 clients was originally selected for the study sample.[5]

Existing state databases were used to collect outcome data for these clients from the periods prior and subsequent to their treatment episodes. The databases included the following: CPMS (Client Process Monitoring System), LEDS (Law Enforcement Data System),[6] OPS (Offender Profile System),[7] AFS (Adult and Family Services),[8] OMAP (Office of Medical Assistance Programs [Medicaid]),[9] and CSD (Children's Services Division). Permission to access these databases was gained and confidentiality of clients was protected at all times.[10]

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[4] Because of its small size, the entire population of methadone treatment completers was selected.

[5] There was, however, some inevitable attrition. For some individuals, insufficient identifiers were available to locate them in the database (or the identifiers were incorrect). Some individuals in the sample were deceased; others had moved. This reduced the useable sample to 1125. Finally, with the residential module, some of the non-completers were found to have had considerable treatment experience. For some analyses, they and their matches among the treatment completers were excluded. This attrition did not significantly diminish the power of the subsequent data analysis.

[6] The statewide arrest database.

[7] Oregon Department of Corrections database.

[8] The statewide database containing public assistance payments which include welfare, food stamps, emergency assistance, etc.

[9] The statewide database containing medical assistance (medicaid) payments.

[10] Access to the full Employment Division database was denied; however, some employment data were gathered in an earlier data collection from AFS case files. The employment data in this report are therefore limited to those individuals with AFS case files. These data were not used in the avoided cost analysis.

RESULTS

ARRESTS AND CONVICTIONS

PERCENTAGE OF CLIENTS WHO HAVE ARRESTS AND CONVICTIONS
(Total—all service modules)

Treatment completers had fewer arrests and convictions in the three year period following treatment than did the non-completers. This is illustrated in the table below.

TABLE 1
Percentage of clients with subsequent arrests and/or convictions[11]

	Treatment Complete	Treatment Incomplete	Percent Difference
Percentage who had at least one subsequent arrest	16.6	24.9	33%
Percentage who had at least one subsequent conviction	10.5	15.9	34%
Percentage who committed at least one subsequent drug crime	6.1	9.2	34%
Percentage who committed at least one subsequent property crime	5.8	9.7	40%
Percentage who committed at least one subsequent violent crime	3.6	4.7	23%

There are no statistically significant differences in the arrest and conviction histories between treatment completers and non-completers **prior** to treatment.

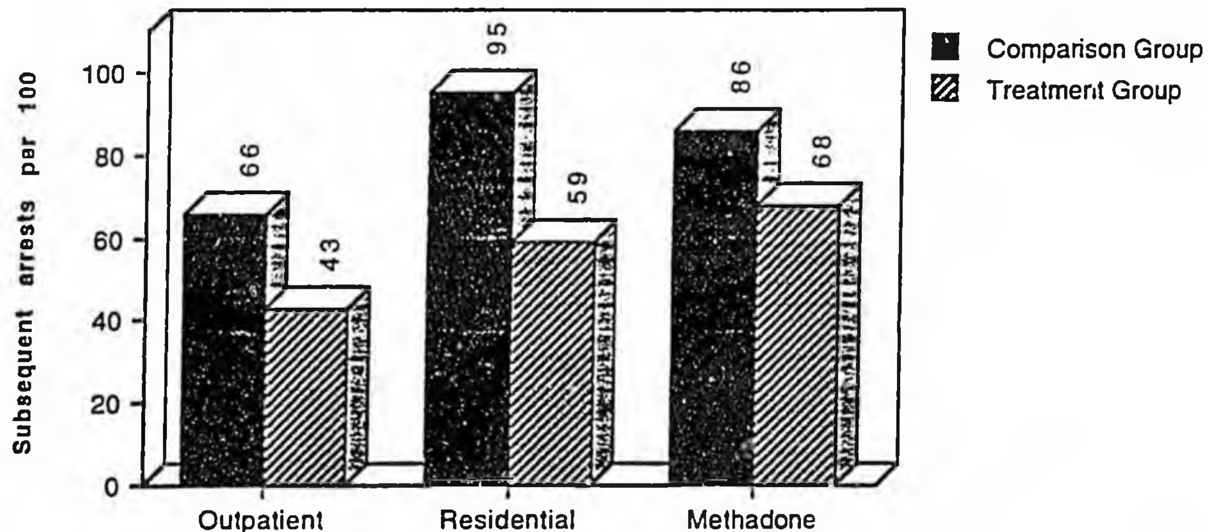
Nearly half of those who completed treatment who had prior arrest records were arrest free in the three years subsequent to treatment. In comparison, only a third of treatment non-completers with prior arrest records were arrest free in the subsequent period.

[11] Chi-square tests, $p<.05$.

ARRESTS
By Treatment Module

Within each module, clients who completed treatment had significantly lower arrest rates than clients in the comparison group.[12]

FIGURE 1
Arrests per 100 clients in the three years subsequent to treatment
By treatment modality



For those that successfully completed *outpatient* treatment (discharged in 1991–1992), the rate of subsequent arrest is 43 per hundred clients, a rate 35% lower than the subsequent arrest rate (66 per hundred) of a matched group of clients with untreated alcohol and drug problems.

For those that successfully completed *residential* treatment (discharged in 1991–1992), the rate of subsequent arrest is 59 per hundred clients, a rate 38% lower than the subsequent arrest rate (95 per hundred) of a matched group of clients with untreated alcohol and drug problems. For untreated residential clients one can expect an average of about one arrest per person over a three year period.

For those that successfully completed *methadone* treatment (discharged in 1991–1992), the rate of subsequent arrest is 68 per hundred clients, a rate 21% lower

---

[12] This analysis (and subsequent ones in this section) differs from that of Table 1 in that it compares the mean number of arrests between the groups and within each module. Tests for statistical significance were based on ANOVA F-ratios. Any differences in prior arrests or convictions between the groups within modules were controlled for in the ANOVA model. Effect of treatment completion vs. non-completion on subsequent arrests: $F=6.13$, $p=.01$.

than the subsequent arrest rate (86 per hundred) of a matched group of those with untreated alcohol and drug problems.

Since it can be estimated that in Oregon there are twelve unreported crimes for every arrest,[13] the following may be suggested:

- For outpatient treatment clients, completion of treatment in 1991 was associated with 276 fewer crimes per hundred drug and alcohol clients or about 17,319 fewer crimes over the subsequent three year period.[14]

- For residential treatment clients, completion of treatment in 1991 was associated with 432 fewer crimes per hundred drug and alcohol clients or about 11,452 fewer crimes over the subsequent three year period.

- For methadone treatment clients, completion of treatment in 1991 was associated with 216 fewer crimes per hundred drug and alcohol clients or about 318 fewer crimes over the subsequent three year period.

In summary, it may be concluded that the completion of treatment by the FY 1991–1992 clients resulted in an estimated **29,089 fewer crimes** over a three year period.[15] In addition, there continued to be treatment completion cohorts (i.e., 1992–1993, 1994–1995) who would have contributed further to the numbers of avoided crimes during that three year period.

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[13] The Bureau of Justice Assistance reported in 1991 that only 38% of all crimes are reported to police (National Crime Victimization Survey Report, 1991, p. 102). According to the BJA Sourcebook of Criminal Justice Statistics, 1991 (p. 462), only 21.6% of offenses reported to police result in an arrest. This means that only about 8% of crimes result in arrest or about one in twelve. Of course, that rate varies by type of crime, with some crimes (e.g., murder) having a higher percentage of arrest and others (e.g., rape) having an even lower percentage of arrest.

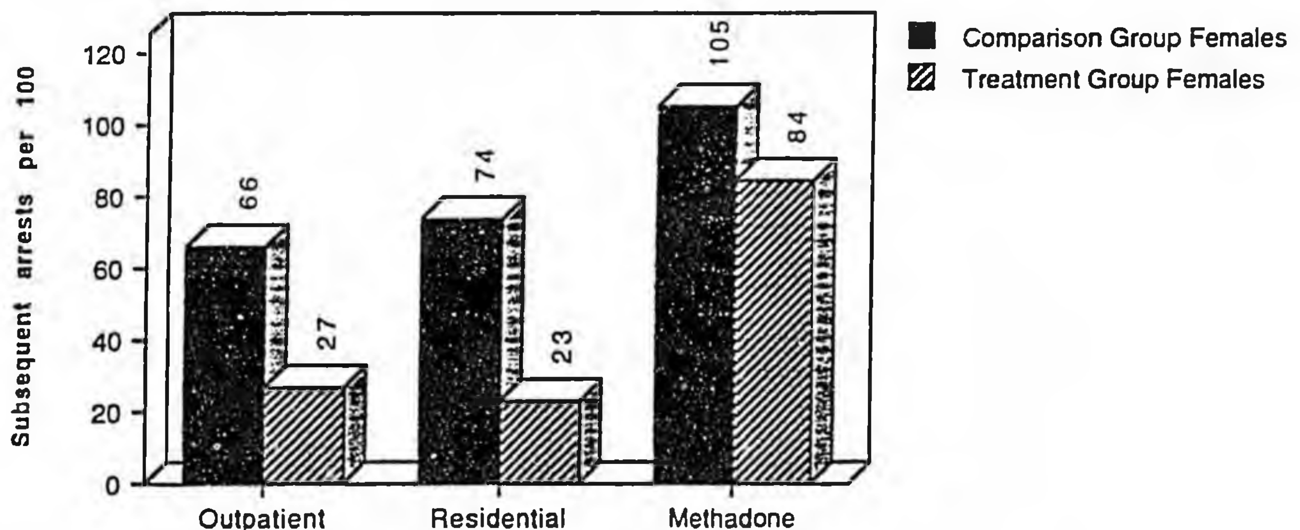
[14] The total number of avoided crimes was calculated for each module by multiplying the number of avoided crimes per person by the total number of clients who completed treatment in that module in 1991.

[15] This does not include traffic offenses (except DUII and motor vehicle theft) or other minor offenses.

FEMALE CLIENTS

The effect of treatment completion on the arrest rate of females is particularly dramatic for outpatient and residential clients.

FIGURE 2
Arrests per 100 female clients in the three years subsequent to treatment[16]
Female client arrests
By treatment modality



For those female clients that successfully completed *outpatient* treatment (discharged in 1991–1992), the rate of subsequent arrest is 27 per hundred clients, a rate **59% lower** than the subsequent arrest rate (66 per hundred) of a matched group of clients with untreated alcohol and drug problems .

For those that successfully completed *residential* treatment (discharged in 1991–1992), the rate of subsequent arrest is 23 per hundred clients, a rate **69% lower** than the subsequent arrest rate (74 per hundred) of a matched group of clients with untreated alcohol and drug problems.

For those that successfully completed *methadone* treatment (discharged in 1991–1992), the rate of subsequent arrest is 84 per hundred clients, a rate **20% lower** than the subsequent arrest rate (105 per hundred) of a matched group of those with untreated alcohol and drug problems.

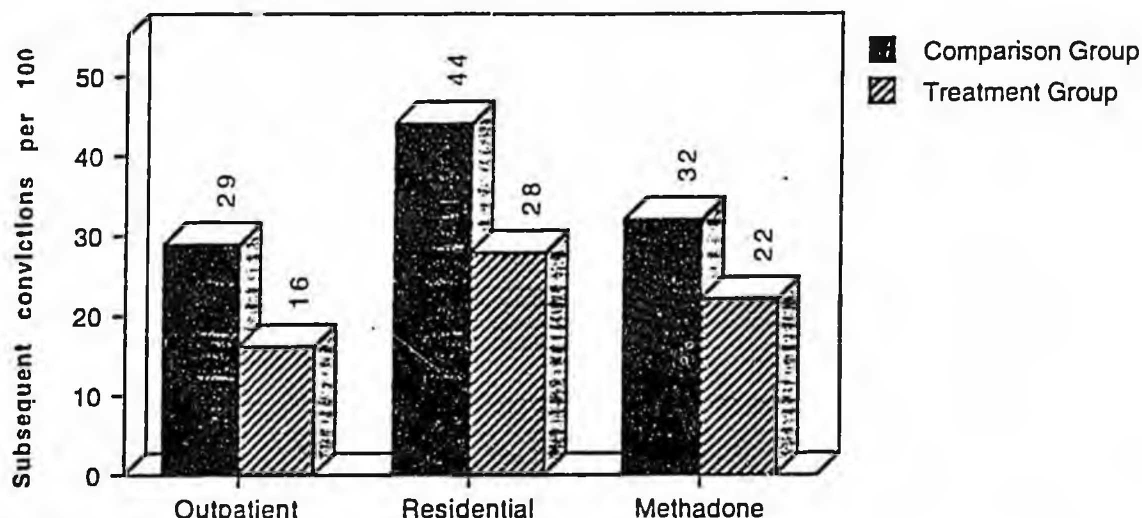
---

[16] Effect of treatment completion vs. non-completion on subsequent arrests: $F=3.3$, $p=.06$..

CONVICTIONS
By Treatment Module

There is also a significantly lower conviction rate for those who completed treatment.

FIGURE 3
Convictions per 100 clients in the three years subsequent to treatment By treatment modality[17]



For those that successfully completed *outpatient* treatment (discharged in 1991–1992), the rate of subsequent conviction is 16 per hundred clients, a rate 45% lower than the subsequent arrest rate (29 per hundred) of a matched group of clients with untreated alcohol and drug problems .

For those that successfully completed *residential* treatment (discharged in 1991–1992), the rate of subsequent conviction is 28 per hundred clients, a rate 36% lower than the subsequent conviction rate (44 per hundred) of a matched group of clients with untreated alcohol and drug problems.

For those that successfully completed *methadone* treatment (discharged in 1991–1992) the rate of subsequent conviction is 22 per hundred clients, a rate 31% lower than the subsequent conviction rate (32 per hundred) of a matched group of those with untreated alcohol and drug problems.

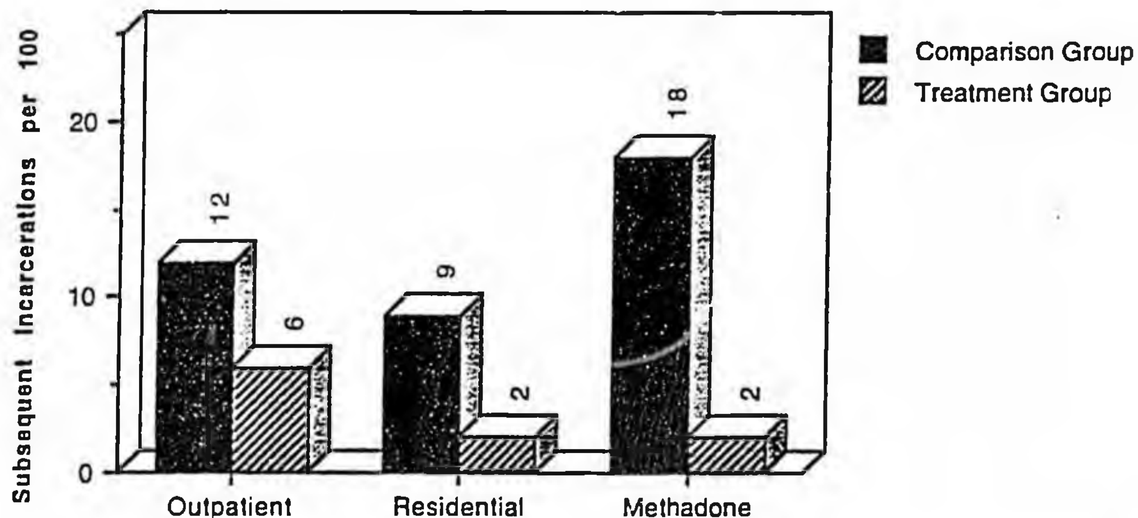
---

[17] Effect of treatment completion vs. non-completion on subsequent convictions: $F=5.2$, $p=.02$.

INCARCERATION

The following represents only those clients incarcerated in the state prison system in the three year period subsequent to treatment. While Department of Corrections data on state prison incarceration were available to us, data on local jail time for specific clients (actual time served) are difficult to acquire and are not included. This, therefore, is a conservative estimate of the reduction of incarceration time for those who completed treatment since it does not include local jail time. Because the data previously presented show reduced arrests and convictions for treatment completers compared to non-completers, we would anticipate that those who completed treatment would also have reduced local jail time .

FIGURE 4
Incarceration episodes per 100 clients in the three years subsequent to treatment[18]
By treatment modality



Treatment completion is associated with substantially fewer incarcerations in the state prison system and fewer days incarcerated.

For those that successfully completed *outpatient* treatment (discharged in 1991–1992), the rate of subsequent incarceration episodes is 6 per hundred clients, a rate 50% lower than the subsequent incarceration rate (12 per hundred) of a matched group of clients with untreated alcohol and drug problems .

For those that successfully completed *residential* treatment (discharged in

---

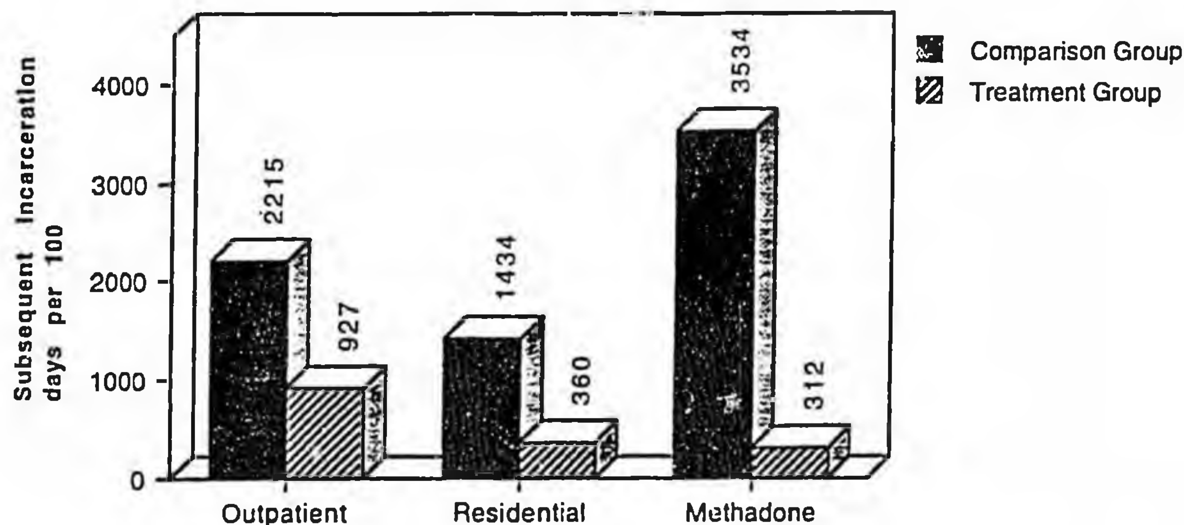
[18] Effect of treatment completion vs. non-completion on subsequent incarcerations: $F=8.7$, $p=.003$.

1991–1992), the rate of subsequent incarceration episodes is 2 per hundred clients, a rate 78% lower than the subsequent incarceration rate (9 per hundred) of a matched group of clients with untreated alcohol and drug problems.

For those that successfully completed *methadone* treatment (discharged in 1991–1992), the rate of subsequent incarceration episodes is 2 per hundred clients, a rate 89% lower than the subsequent incarceration rate (18 per hundred) of a matched group of those with untreated alcohol and drug problems.

These lower incarceration rates result in substantially fewer days incarcerated per hundred clients as seen in the figure below.

FIGURE 5
Incarceration days per 100 clients in the three years subsequent to treatment[19]
By treatment modality



For those that successfully completed *outpatient* treatment (discharged in 1991–1992), the rate of subsequent incarceration days is 927 per hundred clients, a rate 58% lower than the subsequent days of incarceration rate (2215 days per hundred clients) of a matched group of clients with untreated alcohol and drug problems.

For those that successfully completed *residential* treatment (discharged in 1991–1992), the rate of subsequent incarceration days is 360 days per hundred clients, a rate 75% lower than the subsequent days of incarceration rate (1434 days per hundred) of a matched group of clients with untreated alcohol and drug problems.

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[19] Effect of treatment completion vs. non-completion on subsequent arrests: $F=10.6$, $p=.001$.

For those that successfully completed *methadone* treatment (discharged in 1991–1992), the rate of subsequent incarceration days is 312 per hundred clients, a rate 91% lower than the subsequent days of incarceration rate (3534 per hundred) of a matched group of those with untreated alcohol and drug problems.

EMPLOYMENT

Data on employment were gathered from AFS (Adult and Family Services) files.[20] These data show that, for this sample, in the period subsequent to treatment, the wages paid to treatment completers were 65% higher than the wages paid to those who did not complete treatment. The advantage in subsequent wages is observed for clients in all service modules (outpatient, residential, and methadone) but is greatest in the methadone module where treatment completers earned more than twice as much as non-completers.

TABLE 2
Earnings in the three years subsequent to treatment
By treatment modality[21]

GROUP	EARNINGS (3 years after treatment episode)	PERCENT DIFFERENCE
Outpatient Comparison	$12,935	
Outpatient Treatment	$19,240	49%
Residential Comparison	$9,250	
Residential Treatment	$16,226	75%
Methadone Comparison	$4,532	
Methadone Treatment	$10,673	136%

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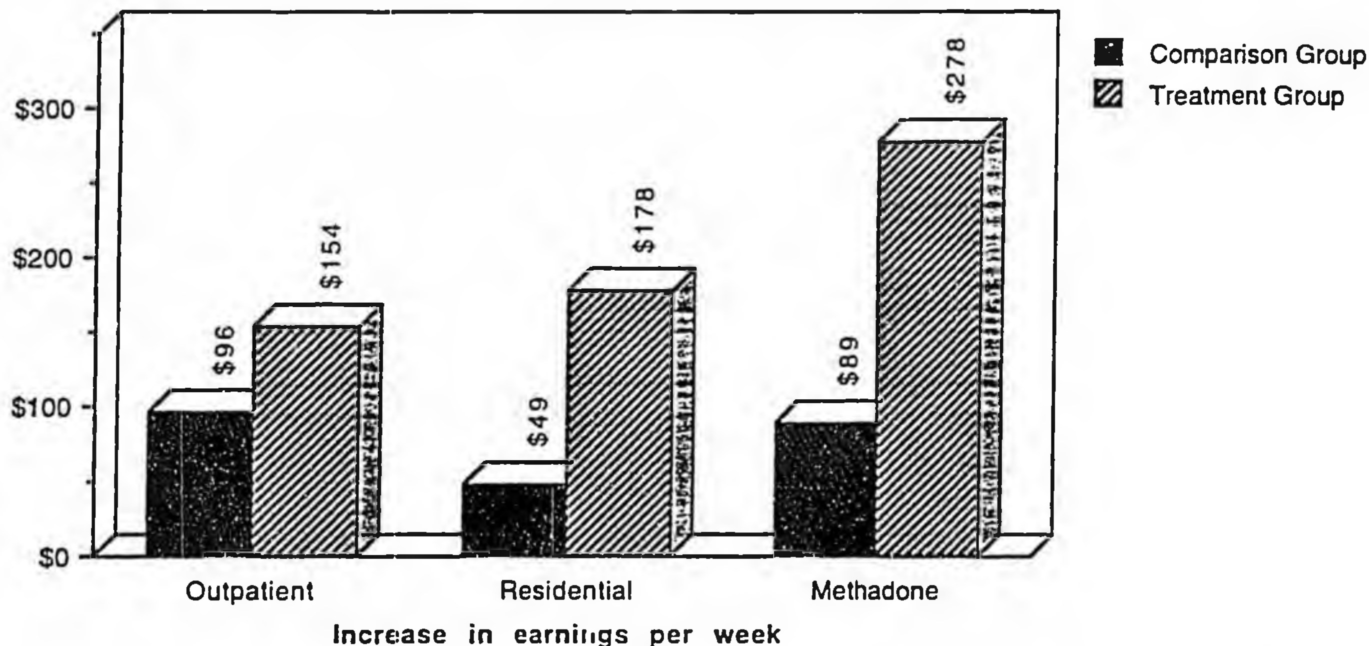
20 Direct access to Employment Department records was not possible. Employment information was gathered through the AFS data system after clients were identified by a case number, name, and date of birth search. Thus, the employment data that we have reflect only those clients that could be tracked in the AFS files. (Six hundred ninety-seven cases, about two thirds of the sample, were trackable in AFS; 483 had employment earnings.) For all modules, trackable and non-trackable clients were fairly evenly distributed between treatment completers and non-completers. The individuals for whom information was found likely represent the poorest clients in the sample, and since our interest here is in assessing the expenditure of public assistance money on this population, these clients are clearly the most relevant to the study.

21 Effect of treatment completion vs. non-completion on subsequent earnings, controlling for prior earnings: $F=17.0$, $p=.0001$.

This increase in wages earned was due to two factors: an improvement in the earning power of clients (per week) and an improvement in the number of weeks worked in the period subsequent to treatment.

FIGURE 6
Improvement in earnings per week[22]
(Pre-treatment to post-treatment)
By treatment modality



Increase in earnings per week

While treatment non-completers also had modest increases in their average earnings in the weeks in which they worked, treatment completers had far greater increases. This occurred across every module. For example, residential treatment non-completers earned about $49 more per week in the weeks they worked during the three year period subsequent to their incomplete treatment than they had in the two year period prior to treatment. However, residential treatment completers earned about $178 more per week in the weeks they worked during the three year period subsequent to their treatment than they had in the two year period prior to treatment. This represents a 250% better earnings performance by treatment completers than by non-completers.

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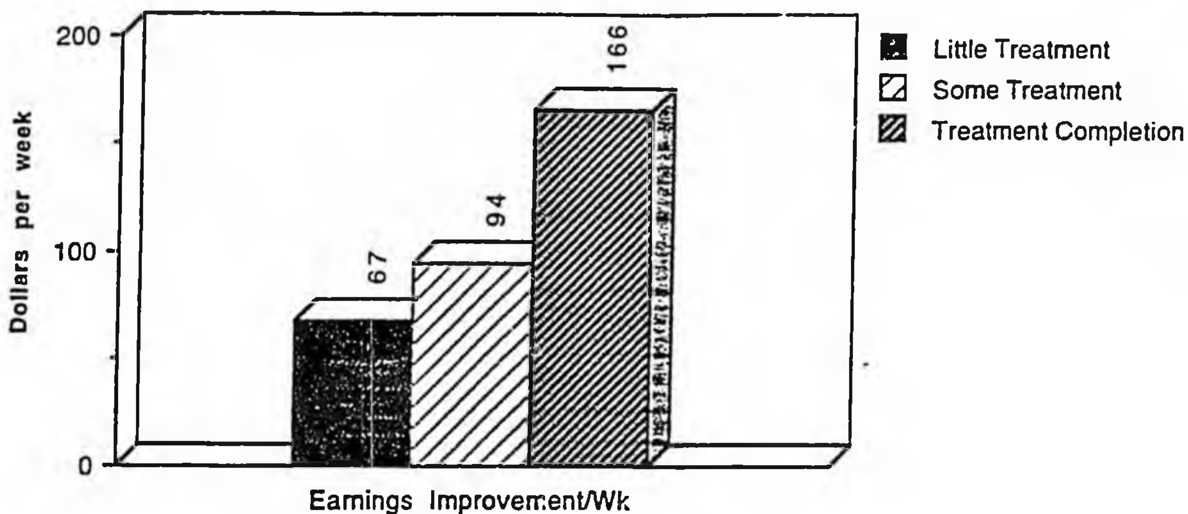
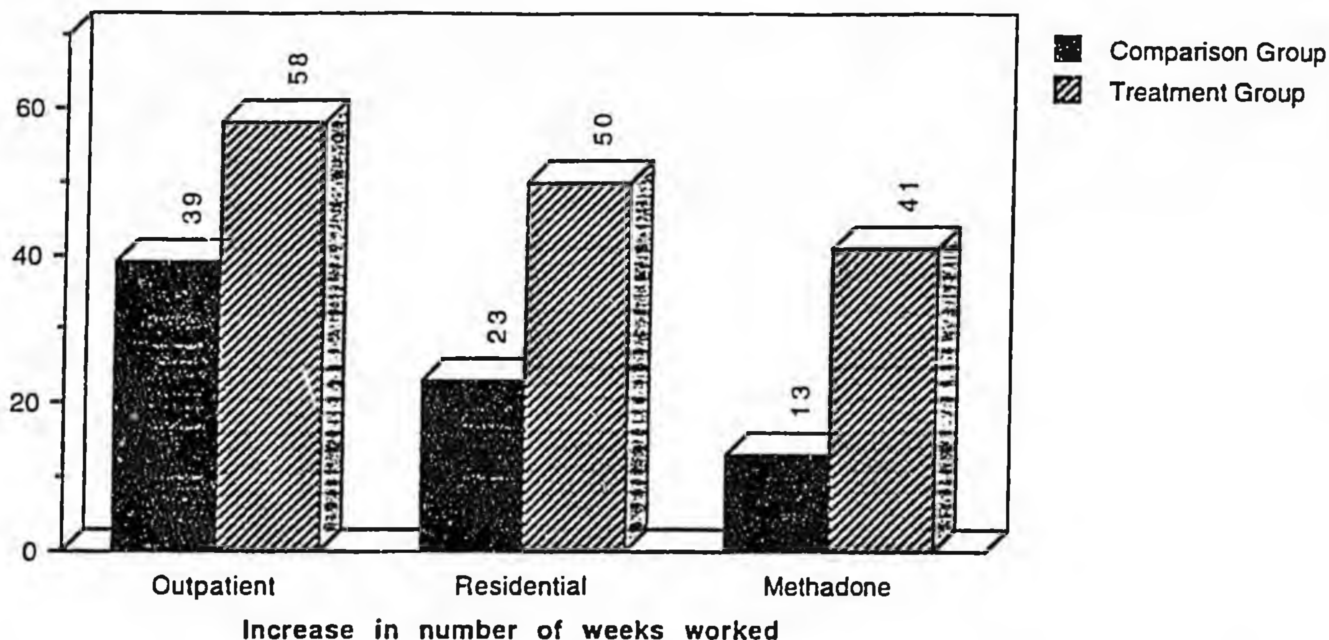
22 Effect of treatment completion vs. non-completion on improvement in earnings per week: $F=3.9$, $p=.05$.

FIGURE 7
Improvement in Earnings per Week
(Pre-treatment to post-treatment)



Among the non-completers, those who had even some treatment had greater improvements in their average earnings in the subsequent period than those non-completers whose only exposure to treatment was an intake session.

FIGURE 8
Improvement in the number of weeks worked[23]
(Pre-treatment to post-treatment)
By treatment modality



While treatment non-completers also had modest increases in their average number of weeks worked, treatment completers had far greater increases. This occurred across every module. For example, residential treatment non-completers worked an average of 23 more weeks during the three year period subsequent to their incomplete treatment than they had worked in the two year period prior to treatment. However, residential treatment completers worked an average of 50 more weeks during the three year period subsequent to their treatment than they had worked in the two year period prior to treatment. This represents a 117% better performance by treatment completers than by non-completers.

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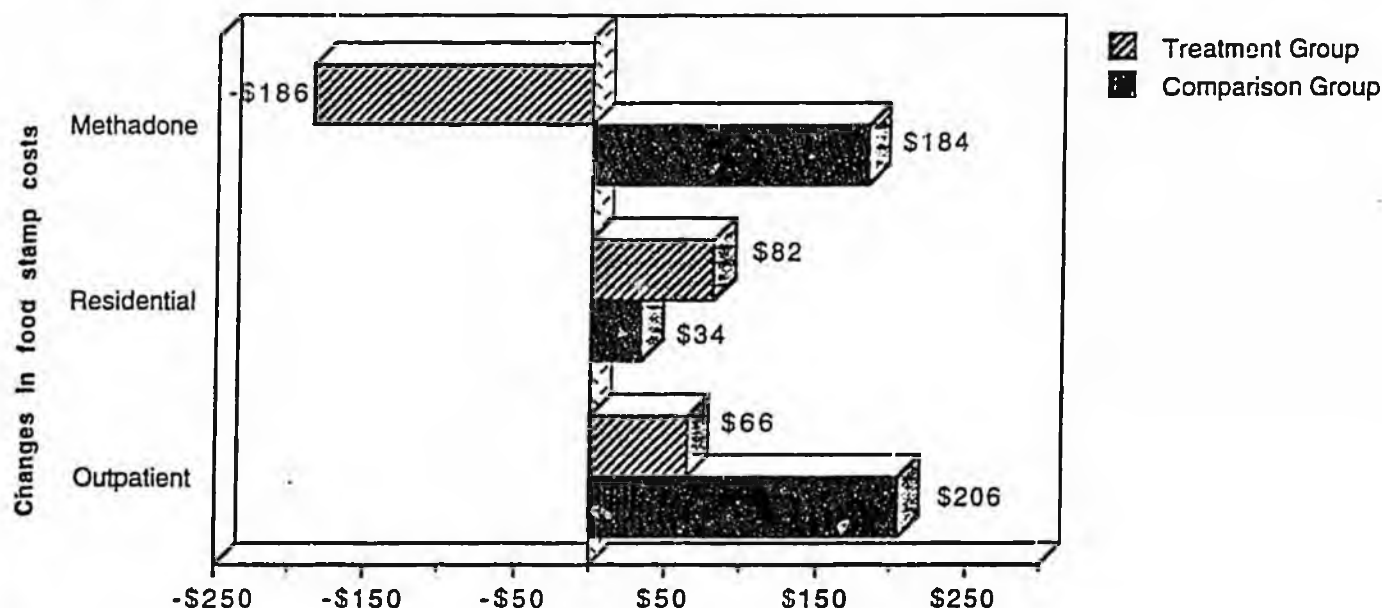
[23]Effect of treatment completion vs. non-completion on improvement in weeks worked subsequent to treatment: F=13.3, p=.0001.

FOOD STAMP ASSISTANCE

Records of the history of food stamp assistance provided to clients through AFS were available on micro-fiche. A search was made for the clients in the sample for the period two years prior and three years subsequent to treatment.

FIGURE 9
Food stamp assistance in the three years subsequent to treatment[24]
By treatment modality



The average increase in food stamp assistance was reduced significantly for outpatient clients who completed treatment compared to those who were non-completers. The treatment group had an increase per hundred clients that was one-third of the increase in food stamp assistance experienced by the comparison group. Methadone clients who completed treatment had a significant decline in food stamp assistance while clients in the non-completing comparison group had significant increases. Residential treatment completers showed a reverse trend although it was not statistically significant.

The above data reflect the total increase in food stamp assistance per hundred clients in the period subsequent to treatment. As such, it includes persons who were not receiving food stamps in the pre-treatment period. One aspect of residential treatment, which involves more "case management," is an effort to ensure that clients receive

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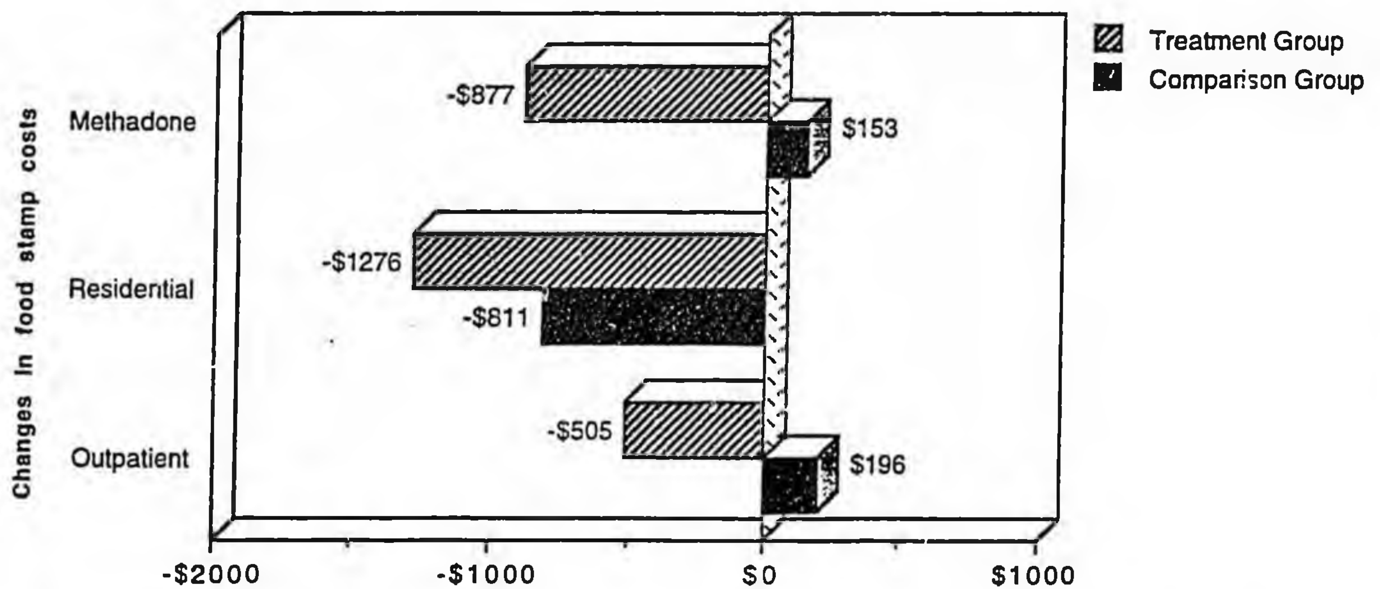
[24] Effect of treatment completion vs. non-completion on decreases in food stamp assistance: $F=3.2$ $p=.07$.

food stamps if they are eligible. Residential providers actually receive food stamps as income for their programs during the period that clients are in residency, motivating residential providers to apply for food stamps for any eligible client who is not currently receiving them. Residential clients may also be encouraged to change employment as a treatment option, thereby potentially increasing food stamp usage temporarily. These factors tend to produce temporary increases in food stamp use by residential treatment completers (and by methadone completers as well).

A separate analysis was undertaken to look at only those clients who had a record of food stamp assistance in the pre-treatment period in order to isolate the specific effects of treatment on food stamp assistance. Records of these clients were examined for both pre-treatment and three year post-treatment periods.

FIGURE 10
Changes in food stamp assistance[25]
(Pre-treatment to post-treatment)
By treatment modality



All three treatment completion groups showed dramatic decreases in their use of food stamps in the three year period subsequent to the completion of treatment. All the decreases are significant beyond the .01 level. Clearly, treatment completion is associated with a dramatic drop in food stamp use for those clients who used food stamps in the pre-treatment period. Oddly, the residential non-completers who were on food stamps in the pre-treatment period also showed a decline in food stamp

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[25] Effect of treatment completion vs. non-completion on decreases in food stamp assistance: $F=3.2$, $p=.07$.

assistance (although less than the matched treatment completing clients). One possible explanation is that since this group is arrested and convicted at much higher rates than any of the other groups (see previous graphs in the criminal justice section of this report), they perhaps spend enough time in jail or on the run in the subsequent period to significantly reduce their ability to use food stamps.

CHILDREN'S SERVICES DIVISION[26] INVOLVEMENT

Data from Adult and Family Services' files were used to determine whether clients in these samples were connected to cases in which the Children's Services Division had become involved. Although CSD involvement implies that some kind of child mistreatment may be occurring, assessing the actual responsibility of the sample clients is complex. It is not always possible to know absolutely that a particular client is at fault in a case. Nonetheless, CSD cases are costly to the taxpayer even to investigate, and because the purpose of this study is to examine where costs were avoided, these data are included.

Results show the following: the percentage of treatment completers with CSD (Children's Services Division) involvement decreased from 7.8% before treatment to 3.9% after treatment, a 50% reduction; the percentage of non-completers with CSD involvement decreased from 7.6% before treatment to 5.9% after treatment, a 22% reduction. Whether, in individual cases, the decrease is due to the effects of treatment completion per se is conjectural, but the avoided costs to taxpayers for the group of treatment completers can be assessed.

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[26] Very recently CSD has changed its name to SCF (State Office for Services to Children and Families).

MEDICAL COSTS

Medical claims for public assistance were available through the Office of Medical Assistance Programs (Medicaid) in the Oregon Department of Human Resources. Data were searched for claims from the 1989 to 1995 period.

TABLE 3
Increases in medical claims[27]
By treatment modality

GROUP	PRE-TREATMENT COSTS	POST-TREATMENT COSTS	INCREASE IN MEDICAL COSTS
Outpatient Comparison	$495	$1114	$619
Outpatient Treatment	$480	$1007	$527
Residential Comparison	$133	$489	$356
Residential Treatment	$213	$403	$190
Methadone Comparison	$803	$4812	$4009
Methadone Treatment	$1845	$2194	$349

All categories of clients showed increases in paid claim amounts from the pre-treatment period to the post-treatment period. However, in all cases the increases for clients who completed treatment are lower, often substantially lower than for those who were non-completers. The results particularly illustrate the staggering expense to the medical system of opiate-using clients who are candidates for methadone treatment but who fail to remain in treatment.

A situation that brings complexity to the interpretation of these data is the tendency of some clients who complete treatment to use medical facilities more initially following treatment than they had before, as their new clean and sober status allows them to tend to unmet medical needs. Another complexity affecting these data is that the 1991–92 period was one in which a number of slots for pregnant women were

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[27] Effect of treatment completion vs. non-completion on increases in medical costs: $F=5.5$, $p=.02$.

opened, particularly in residential treatment. As a result, many of the women who completed treatment filed numerous medical claims in the post-treatment period reflecting the expenses surrounding their pregnancies. When the analysis of claims is separated by gender, a clearer pattern emerges.

TABLE 4
Post-treatment paid medical claims
By treatment modality and gender

GROUP	MALE	FEMALE
Outpatient Comparison	$1015.04	$1333.58
Outpatient Treatment	$890.74	$1245.73
Residential Comparison	$323.89	$786.07
Residential Treatment	$141.89	$883.74
Methadone Comparison	$2572.74	$6433.42
Methadone Treatment	$757.07	$3096.26

Female paid claims for treatment completers are considerably higher than for males (particularly in residential care). The difference is at least partly an artifact of the preference given to pregnant women who entered into the treatment system during this period (1991–1992) and completed treatment.[28] When only male clients are examined, the reduction in paid claims accruing from treatment completion is apparent across all treatment modalities.

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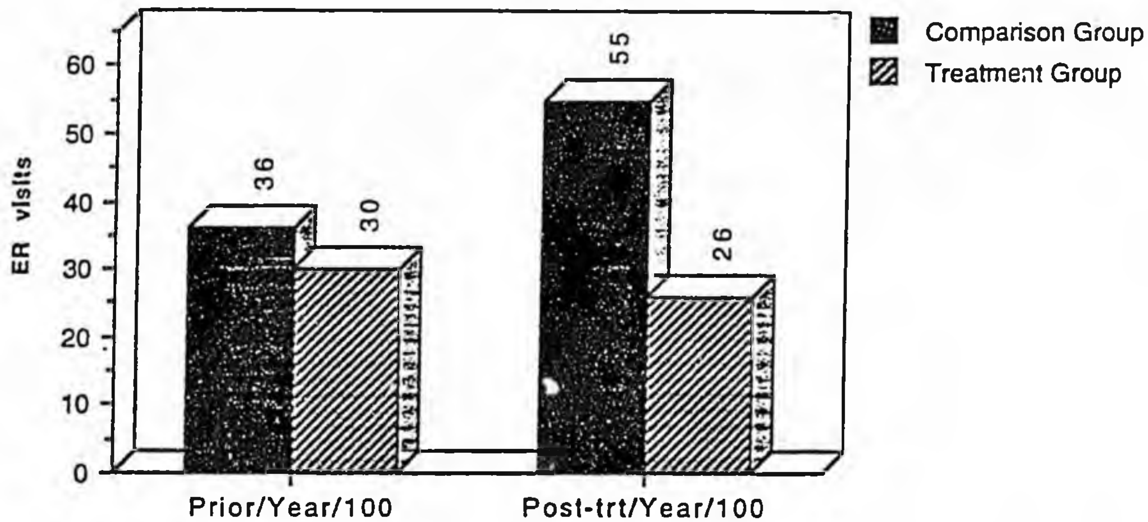
[28] This information came from a canvas of treatment providers.

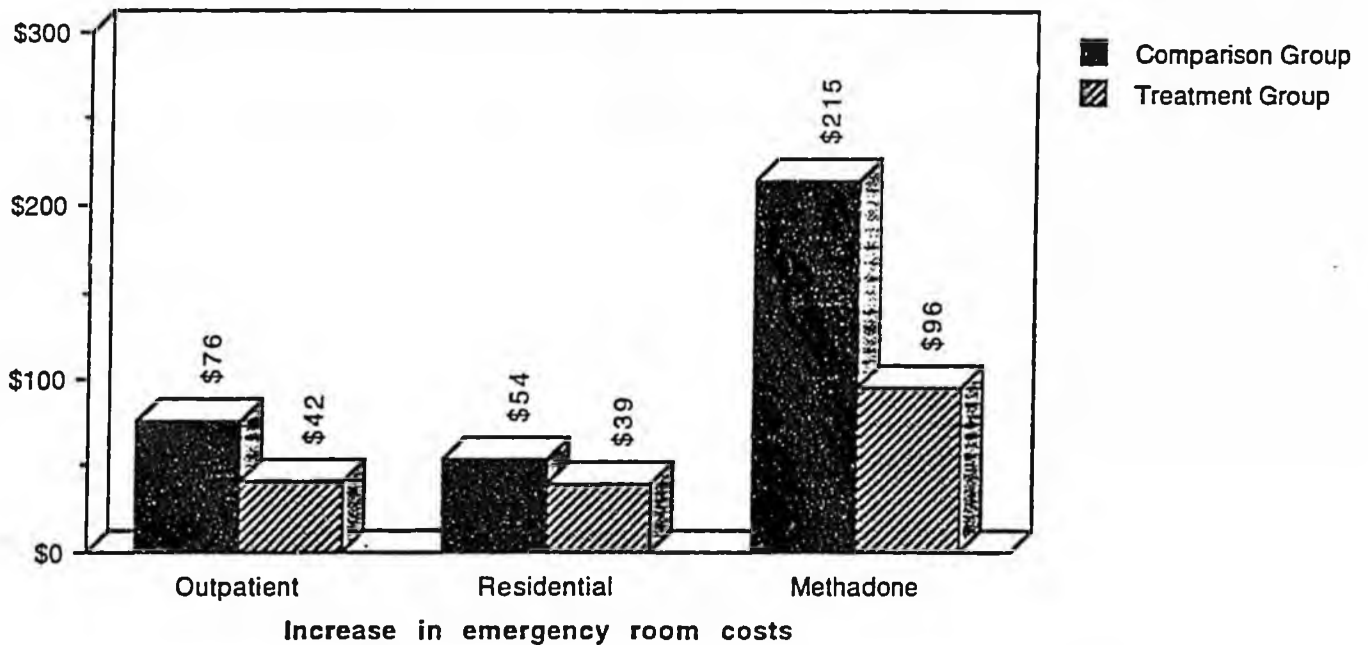
FIGURE 11
Number of Emergency Room Visits per Year per Hundred Clients
(Pre-treatment to post-treatment)



The national research literature indicates that impoverished alcohol and drug clients tend to use hospital emergency room services for routine care rather than using these services only in true emergencies. The data for Oregon clients show a dramatic increase in the use of the emergency room during the period following treatment by those who did not complete treatment compared to a slight decrease of emergency room use by those who did complete treatment. In the post-treatment period, treatment completers had 53% fewer emergency room visits than clients who did not complete treatment.

It follows that the cost of claims for emergency room use were less for the treatment group than for the comparison group.

FIGURE 12
Emergency room costs[29]
(Pre-treatment to post-treatment)
By treatment modality



Increase in emergency room costs

The average cost increase in emergency room claims for those who completed treatment was lower than the increase for non-completers in all modules. The cost increase for outpatient treatment completers was 45% less, for residential completers it was 30% less, and for methadone completers it was 55% less than for the clients in the respective comparison groups.

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[29] Effect of treatment completion vs. non-completion on increases in emergency room costs: $F=10.3$, $p=.001$.

COSTS AND AVOIDED COSTS OF TREATMENT

METHOD

Current research has calculated the benefits of treatment primarily by focusing on "avoided costs." These are costs that would have accrued had the alcohol or drug clients not received treatment. This approach is used in this study.[30]

The specific strategy used here is a "Cost to Taxpayers" approach that focuses on the costs related to untreated substance abuse that come directly from the pockets of taxpaying citizens. The focus is not so much on the benefits (or avoided costs) to successful substance abuse treatment completers in their own lives as it is on the benefits (or avoided costs) to non-substance abusing citizens. In this approach, any cost that is the result of untreated substance abuse and that directly impacts a citizen (either through tax-related expenditures or the results of being a victim of a crime perpetrated by a substance abuser) is used in calculating the avoided costs of substance abuse treatment.

AVOIDED COSTS TO TAXPAYING CITIZENS

In assessing the avoided costs resulting from the positive outcomes of treatment described earlier, we have defined the following as costs:

Criminal Justice System Costs: the cost of police protection services, prosecution, adjudication, public defense, and corrections (incarceration and parole/probation).

Victim Losses: victim expenditures on medical care, repairs of damaged property, and lost time from work that results from predatory crimes.

Theft Losses: the estimated value of property or money stolen during a crime, excluding any property damage or other victim losses.

Health Care Service Utilization: the economic cost to the taxpayer in public assistance of inpatient, outpatient, and emergency medical care, and inpatient and outpatient mental health care that could have been avoided.

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[30] In examining costs, current research has distinguished two main strategies: "Costs to Society" and "Cost to Taxpayers" (see CALDATA, 1994; Rice, et al 1990, Harwood, 1984). The "Costs to Society" strategy measures the avoided costs accruing from substance abuse treatment in terms of the loss to society's net productivity. The net loss of productivity and income because of drug or alcohol abuse is measured and used as a benefit (avoided cost) of treatment. The value of goods stolen by substance abusers who commit crimes is viewed simply as an economic transfer (from one pocket to another) and no net loss to society. Although the approach has some value, it is not used in this study.

Public assistance: the economic values of such public assistance as food stamps, emergency assistance, public disability payments, and other public assistance

The following sources have been used. Wherever it was possible, actual Oregon data were used in the calculations of costs.

TABLE 5
Data sources

Components	Sources of Data
CRIMINAL JUSTICE	
Police Protection from Crime	Oregon data from Bureau of Justice Statistics, 1991
Adjudication	Data from a sample of local courts and Oregon data from Bureau of Justice Statistics
Jail	Sample of five Oregon jails includes booking record data
Corrections	Oregon Department of Corrections, data on sample from Oregon Department of Corrections' Offender Profile System
Victim Costs	Center for Substance Abuse Prevention data on Oregon victimization Bureau of Justice Assistance Criminal Victimization Report, 1991
HEALTH	
Hospital Costs	Office of Medical Assistance Programs (OMAP) data
Physician Costs	OMAP data
Emergency Room	OMAP data
PUBLIC ASSISTANCE	
CSD	Data from Adult and Family Services (AFS) system
Employment	Data from AFS system
AFS	Data from AFS system. Archived data on micro-fiche/case records

The method of calculating the costs involved has been kept similar to that used in the CALDATA study for purposes of comparison.

RESULTS

The process of gathering and analyzing these data has been complex. However, the following conservative estimations can be made using the completed analysis of costs per person and the total avoided costs to Oregon taxpayers for the 1991–1992 cohort of drug treatment completers:

TABLE 6
Avoided costs by treatment module

MODULE	COST PER PERSON	1991-92 CLIENTS COMPLETING TREATMENT	TOTAL SAVINGS
OUTPATIENT			
Comparison	$22,047		
Treatment	$13,938	6275	
SAVINGS	**$8,109**	X 6275 =	$50,884,666
RESIDENTIAL			
Comparison	$30,039		
Treatment	$18,494	2651	
SAVINGS	**$11,545**	X 2651 =	$30,604,523
METHADONE			
Comparison	$31,763		
Treatment	$20,484	147	
SAVINGS	**$11,279**	X 147 =	$1,657,998
TOTAL			**$83,147,187**

We can estimate that the 1991–1992 cohort of treatment completers (for residential, outpatient, and methadone modules combined) produced avoided costs to Oregon taxpayers of $83,147,187 in the two and a half years of full data collection from 1992–1995. It should be noted that these are the cost savings produced by treatment completers only. There is another group of clients (who were not part of this study) who received a good deal of treatment in the 1991–92 FY, but who did not complete treatment. From the data on employment (Figure 7) and from other research, we can expect this group of clients to also have positive societal outcomes and avoided costs. This indicates that the avoided cost estimates are conservative.

The costs can be distributed in the following way among these cost categories.

TABLE 7
Avoided costs categories

CATEGORY	AVOIDED COSTS
Criminal Justice	$21,222,945
Public Assistance	$3,222,963
Victim	$23,480,512
Theft	$35,220,767
Total	$83,147,187

Approximately $24,450,000 of the total are costs avoided by state and local governments. These are costs that would have to be assumed by these governmental budgets if treatment completion had not occurred. The costs include increased expenditures for police protection, court costs, supervision costs, jail and prison costs,[31] increased medical assistance, food stamps, and other public assistance. Victim and theft costs represent the probable cost resulting from increased criminal activity to taxpaying citizens from their own pockets. It should be noted that in all cases where actual costs could not be measured, the estimates are conservative. In addition, access to some avoided cost data (such as unemployment compensation data) was unavailable. It is likely therefore that these figures represent the minimum savings.

THE COSTS OF TREATMENT VS THE COST SAVINGS OF TREATMENT

According to figures from the Office of Alcohol and Drug Abuse Programs, an estimated $14,879,128 in tax money was spent on the 1991–1992 cohort of clients who received treatment. With the estimated total of $83,147,187 of avoided costs savings, we calculate that every taxpayer dollar spent on those who completed treatment in 1991–1992 produced $5.60 of avoided costs savings to the taxpayer. Furthermore, additional (unknown) savings presumably accrued from those clients who received a good amount of treatment but who did not complete treatment.

CONCLUSION

These results, similar to results found in studies in other states, suggest that successful

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[31] It has been argued that some fixed costs for jails and prisons should not be included in these estimates since some additional new prisoners might be absorbed into the system. However, here we are estimating the impact of thousands of new arrests and convictions on an already overcrowded jail and prison system, making necessary the building of new jails and prisons.

drug and alcohol treatment can have positive societal outcomes. While previous studies have shown the positive effects of treatment for the time period of one year, this study indicates that these gains are sustained over longer periods of time (up to three years). By using existing state databases rather than self-reported data (often used in other studies), this study has the advantage of providing estimates of actual behavior (arrests, food stamp use, etc.). Taken together, this study and others that have preceded it, represent a strong case that drug and alcohol treatment does have positive societal benefits. Using an avoided cost estimates approach, we have been able to estimate the cost savings to taxpayers, either directly in their avoidance of criminal losses or indirectly in the avoidance of the expenditure of their tax dollars, that accrue from the positive societal outcomes of treatment.

A Model Prison Rehabilitation Program: An Evaluation Of The "Stay'n Out" Therapeutic Community

A FINAL REPORT TO THE NATIONAL INSTITUTE ON DRUG ABUSE

August 31, 1988

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EXECUTIVE SUMMARY

There is a pervasive belief in the fields of substance abuse and corrections that prison-based rehabilitation is ineffective and treatment efforts should be reserved for the community. The environment of correctional institutions typically impedes attempts at both treatment and research. Thus, it is quite difficult to sustain treatment programs and research studies within correctional facilities. In spite of this, prison officials in New York State, the administrators of a drug treatment program, and evaluation researchers succeeded in forming a cooperative relationship that has lasted more than a decade. The research presented in this Final Report is the culmination of a joint venture designed to test the proposition that effective treatment of substance abusers is possible within prison.

The positive treatment findings presented in this Final Report on the Stay'n Out program, a therapeutic community (TC) that has operated for eleven years in two New York State prisons, is the culmination of a landmark study in the field this represents the first large scale study that provides convincing evidence that prison-based therapeutic community treatment can produce significant reductions in recidivism rates. Indeed, dissemination of preliminary results has already had an important impact on the field and has generated interest as well as funding to support effective treatment for substance abusers while in prison. Initially, the goals of the outcome evaluation research were to:

- evaluate the effectiveness of the Stay'n Out program in reducing recidivism and compare its effectiveness to alternative treatment modalities;
- identify the factors that contribute to treatment effectiveness, including offender characteristics, program attributes, and post-release experiences;
- assess the effect of time in program on treatment outcomes;
- describe a model of prison treatment programs based on the evaluation of Stay'n Out and a survey of the state-of-the-art in prison-based drug treatment;
- develop recommendations for prison treatment that would apply the research findings to the practical concerns of treatment professionals and policymakers.

Components of the Evaluation Research

This Final Report describes the research conducted in "An Outcome Evaluation of a Prison-based Therapeutic Community for Male and Female Substance Abusers" (funded by the National Institute on Drug Abuse grant 2-R18-DA03310). To achieve the project's goals, the research consisted of an investigation into two main areas:

1. The Status of Prison-based Drug Treatment Programs

The project sought to develop a model for prison treatment programs by examining the Stay'n Out program and several other highly regarded prison treatment programs. At the program level, a major, dual concern was with the obstacles to successful implementation of treatment programs in prisons and the conditions necessary for effective treatment. First, a review of the literature relevant to evaluations of drug treatment programs (focusing especially on "what works") was completed. Second, a survey of the state-of-the-art in prison drug treatment was conducted. Fifty-nine exemplary programs were nominated by about half the states; eight of these were deemed model programs. Third, site visits to the Stay'n Out program were made to document aspects of its implementation.

2. Examination of the Factors Related to Treatment Outcomes

Another major thrust of the research was to evaluate the effectiveness of the Stay'n Out program. The project was to identify the offender characteristics and experiences (before, during, and after treatment) that are related to treatment outcomes. First, background characteristics of all male and female Stay'n Out clients (demographics, employment and income, drug abuse and treatment, criminal histories, and treatment duration) were assessed from a data set compiled by the New York State Division of Substance Abuse Services (DSAS).

Second, in-depth analyses were performed in two substudies: (1) an analysis of a sample of 20 successful clients (essentially crime and drug-free for two years after release from prison) and 20 unsuccessful clients (i.e., reincarcerated within two years after release from prison), and (2) an assessment of the initial 90 days after release from prison (n+36), which is perhaps the most critical period for many ex-offenders. In both studies, detailed information was self-reported on their relationships with family and friends, living conditions, employment and education, crime and incarceration histories, drug use and treatment. The analyses were intended to provide details about the relationship between the life experiences of clients (including treatment in prison) and their behavior after release from prison.

Third, a large scale, quantitative analysis relating several measures of treatment outcome (e.g., rearrest, reincarceration) to both client characteristics and program attributes (time in program and termination status) was also conducted. Three large data sets were merged in preparation for the statistical analyses: (1) the DSAS data on client characteristics and termination status described above; (2) data from the NYS Division of Parole, which included additional background information on the clients and several measures of recidivism (e.g., rearrest, parole discharge status); and (3) data from the NYS Department of Correctional Services on each prison term (for new crimes and parole revocation) for all the subjects. Statistical analyses were performed to test several hypotheses about the effectiveness of the Stay'n Out treatment. The two main ones were that the Stay'n Out therapeutic community is more effective at reducing recidivism than no treatment and alternative prison-based drug treatment modalities, and that increases in time in program would be related to reductions in recidivism.

Summary of Findings

1. Clients in the Stay'n Out TC Are an Especially Difficult Group to Treat

Unlike residential TCs, which admit clients on a voluntary basis as well as from court referrals, the Stay'n Out program admits only incarcerated felony offenders. This is an especially difficult group to rehabilitate, with extensive prior involvement in crime, chronic heroin and cocaine abuse and failed drug treatment. On average, male clients in the Stay'n Out program have previously been convicted four times and have been incarcerated for four years (prior to admission into Stay'n Out). Most of the offenders are in prison for robbery (43%), drug sales (18%), or burglary (18%).

The Stay'n Out program admits drug abusers who have been heavily involved in drug use since the mean age of 16.5. Seventy- three percent of the clients have abused opiates and 77% have abused cocaine (and other stimulants). Their attempts at changing their lifestyle--on average they have previously been in two treatment programs for 18 months combined -- have failed. Just over half of them (51%) had completed the Stay'n Out program (as compared to residential TCs which have substantially higher drop-out rates). In spite of the considerable involvement in crime and drugs, our research shows that the Stay'n Out program has been successful at reducing recidivism.

2. After Treatment in Stay'n Out, Clients Have Significant Reductions in Drug Use and Criminality

An analysis of the 90 day re-entry period was performed to examine self-reported drug use and criminality after treatment in Stay'n Out. Prior to Stay'n Out, over half the sample (n=36) used heroin and cocaine frequently (i.e., 4-7 days per week); after treatment in the prison TC only five percent used these drugs frequently. Several influences helped the subjects abstain from drugs. The most significant seems to be the Stay'n Out program. Of the 30 subjects who were able to abstain from the use of hard drugs, 24 believed that Stay'n Out helped them in this regard. Of the other factors that helped them abstain, relationships with intimates seemed most important. Indeed, some subjects stated that they were able to abstain because of having a wife or girlfriend (n=15), children (n=12), and/or close family ties (n=13). Because Stay'n Out emphasizes the development of healthy relationships, it is possible to consider the effect relationships seem to have had on reduced drug use as an effect of the program as well.

Prior to Stay'n Out, 86% of this sample of offenders committed crimes for drug money; after treatment only four subjects (10%) committed crimes, and only one subject (2%) claimed to have done so for drugs. Self-reported involvement in crime was also compared for a subsample of offenders who had previously been released from prison without drug treatment. In the re-entry period after Stay'n Out there was a statistically significant reduction in crime (burglary) and a sizeable reduction in drug dealing (though it was not statistically significant). Furthermore, after Stay'n Out, clients were significantly less likely to associate with criminals than they were after having been released from prison without treatment in a TC. The conclusion based on this limited sample is that drug use and criminality decline after treatment in Stay'n Out. The finding of a decline in self-reported crime is corroborated by the significant reductions in rearrest and reincarceration found among Stay'n Out clients in the large scale recidivism study.

3. <u>Prison-Based TC Treatment Is More Effective Than No Treatment or Other Drug Treatment Modalities</u>

Among the most important findings were that both the male and female TC groups had a significantly lower percent arrested (27% and 18% respectively) than the alternative treatment groups and the no treatment control group. In addition, the male and female TC groups had a higher percent of positive parole discharges than the alternative treatment groups and in the case of female TC group, the no treatment comparison group. Even though there was not much difference in the overall reincarceration rates among the three programs it appears that a significantly higher percentage of clients who complete the program favorably are not reincarcerated (72% within three years) as compared to clients who terminate negatively (61% within three years). Furthermore, time spent in the Stay;n Out TC reduces reincarceration whereas time spent in the comparison modalities does not. The results indicate that the Stay;n Out prison TC was more effective in reducing recidivism among parolees than no treatment or the alternative treatment modalities.

4. <u>Stay'n Out Clients Do Better on Parole If They Are in the Program for 9-12 Months Than if They Terminate from the Program Earlier (or Later)</u>

To test the hypothesis that treatment outcomes improve as time in program increases, several statistical analyses were performed. For example, when clients who completed the program in 9 to 12 months were compared with clients who left within three months differences between the percentages positively discharged from parole for the two treatment periods were significant. Among those who terminated in less than three months, the percent positively discharged was only 49.2%, whereas the rate positively discharged for the group that stayed in the program for the longer period was 77.3%.

We also found that increases in time in TC treatment delays the time until arrest for those who recidivate. When the mean time until arrest was compared for the two termination periods, we found that clients who received less treatment were arrested much sooner than those who stayed in the program 9 to 12 months. Furthermore, the percent of Stay'n Out clients who were not reincarcerated after 9 to 12 months of treatment was considerably higher (72% within three years) than for clients who resigned or were dismissed earlier (60% within three years). Indeed, the odds of not being reincarcerated for clients who remained in treatment for the optimal duration (9 to 12 months) are nearly three times greater than for clients who spend less than nine months in treatment.

Clients who receive 9 to 12 months of treatment are not less likely to recidivate than clients who spend less time in treatment, but they also do better than clients who remain in treatment over one year. This finding was consistent for most of the outcome measures tested (time until arrest, positive parole discharge, reincarceration). Indeed, multiple regression analysis confirmed a statistically significant decline in time until arrest for clients who remained in treatment over 12 months. It should be noted, however, that the clients in this group are still significantly less likely to recidivate that those who terminate from the treatment in less than nine months. *Thus, the central conclusion of this research is that hard core drug abusers who remain in the prison-based therapeutic community longer are more*

likely to succeed than those who leave earlier, and that 9 to 12 months appears to be the optimal duration for the treatment.

5. <u>The Influence of Time in Program on Outcomes was Independent of the Effects of Background Variables</u>

A few of the background variables (age, prior record, mean number of months per prior drug treatment) were significantly related to outcome; however, the effects of these variables were independent of time in program (TIP). Age was the only background characteristic of the clients to be consistently related to success (see Chapters 4, 8, and 9). Nonetheless, regression analysis (Chapter 8) showed that TIP was positively related to time until arrest when other significant background variables (age and criminal history score) were held constant. In addition, while there was a strong association between TIP and reincarceration, the background characteristics of clients were not statistically related to TIP. Indeed, multivariate analyses (logistic regression) demonstrated that increases in time in program were associated with a higher percent of clients not being reincarcerated after controlling for age and prior criminal record (Chapter 9).

In an assessment of the possible influence of the psychological traits of the clients, statistical analyses did not produce significant or systematic associations between several measures of the psychological traits and treatment outcomes (Chapter 10). Furthermore, it is reasonable to assert that the research design (treatment and no-treatment comparison groups) adequately controlled for the subtle effects of motivation, deterrence, and treatment; therefore, these qualitative factors do not alter the basic findings. Thus, while age, prior record and some of the other background factors may be related to program outcome, the critical point is that these relationships do not attenuate the finding that increased time-in program is related to lower recidivism rates.

Research Summary

Special Issue | IBR Web Site: www.ibr.tcu.edu | April 1997

Facts About Legal Offenders!*

- 60-85% have used illicit drugs (based on UAs for arrestees and prison surveys)
- 45% of arrestees for violent or property crimes test positive for drugs
- 33% of state prison inmates have committed drug offenses
- Active drug use increases crime rates by a factor of 4 to 6 times

"A logical, cost-effective, and convenient point of intervention is the time they are in custody." (Lipton, 1995, pg. 5)

However, only about 1 of 10 U.S. prisoners receive any form of drug treatment.

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*Lipton, D. S. (November, 1995). *The Effectiveness of Treatment for Drug Abusers under Criminal Justice Supervision.* National Institute of Justice.

*Lipton, D. S. (February, 1996). Prison-based therapeutic communities: Their success with drug-abusing offenders. *National Institute of Justice Journal*, 12-20.

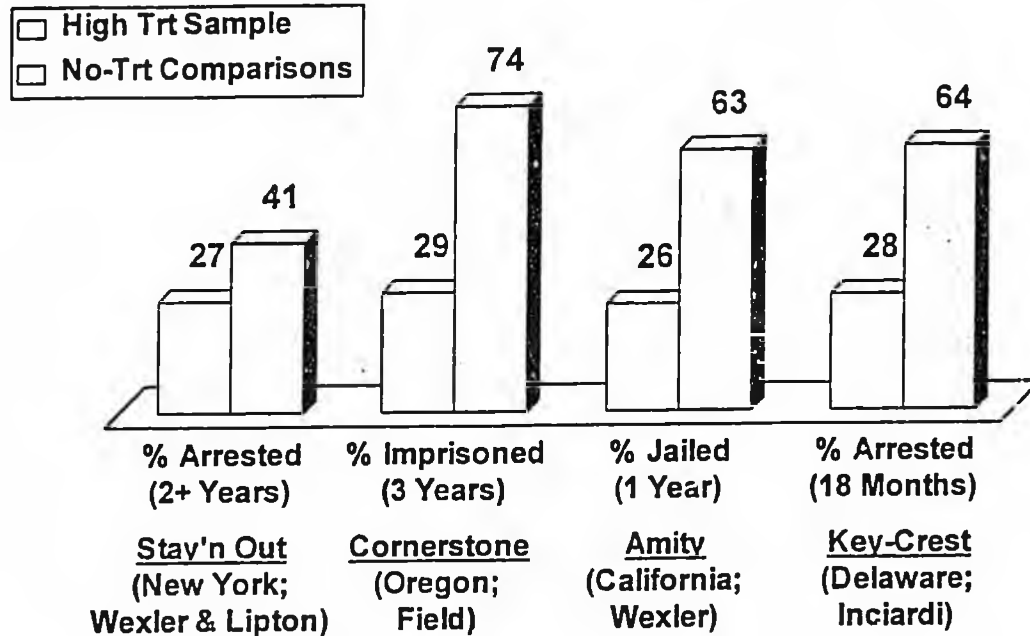
Research Focus of the IBR at TCU

For many years, research staff of the IBR have given special attention to evaluations of substance abuse and behavioral interventions provided by community-based programs, including prevention and treatment and to the study of long-term addiction careers. Research interests have broadened in recent years to include related areas of significant public concern, such as drug abuse treatment in criminal justice settings as well as the spread of AIDS among injecting drug users and methods for reducing these and other high-risk behaviors.

IBR Director: D. Dwayne Simpson, Ph.D., *Associate Director:* Lois R. Chatham, Ph.D.;
Manager of Criminal Justice Studies: Kevin Knight, Ph.D.

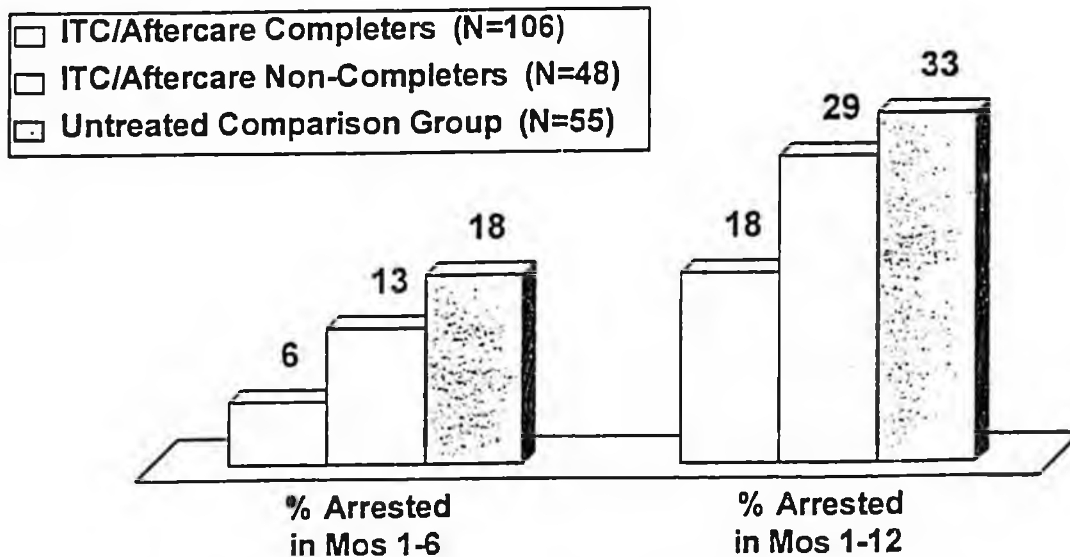
Outcome Studies of Prison-Based Treatment

(Lipton, 1996)



Texas In-Prison Therapeutic Community (ITC) Treatment: 12-Month Arrest Rates*

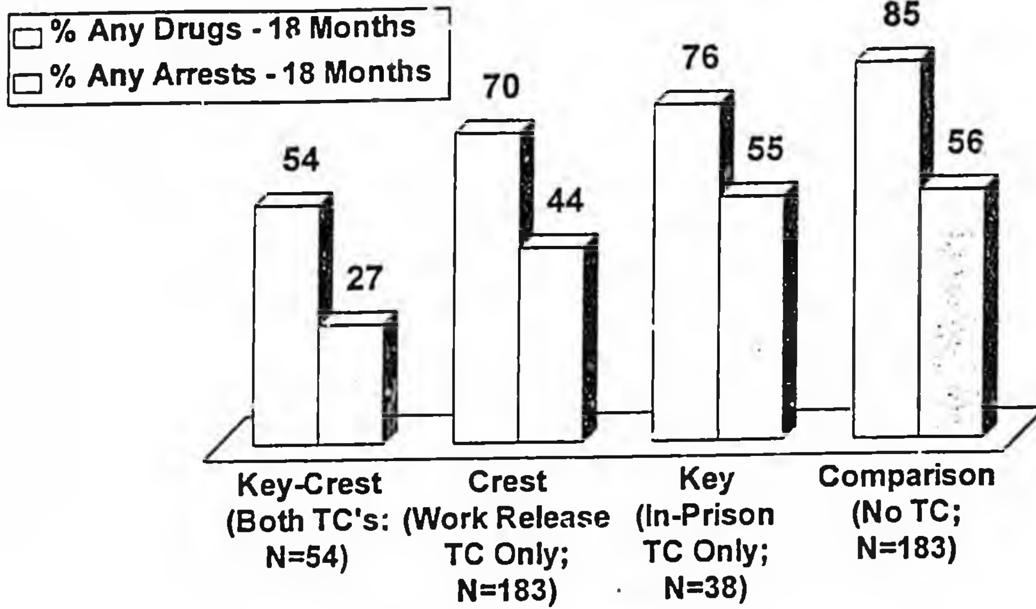
(D. Simpson & K. Knight, Texas Christian University)



[*Based on DPS and Parole Officers Records]

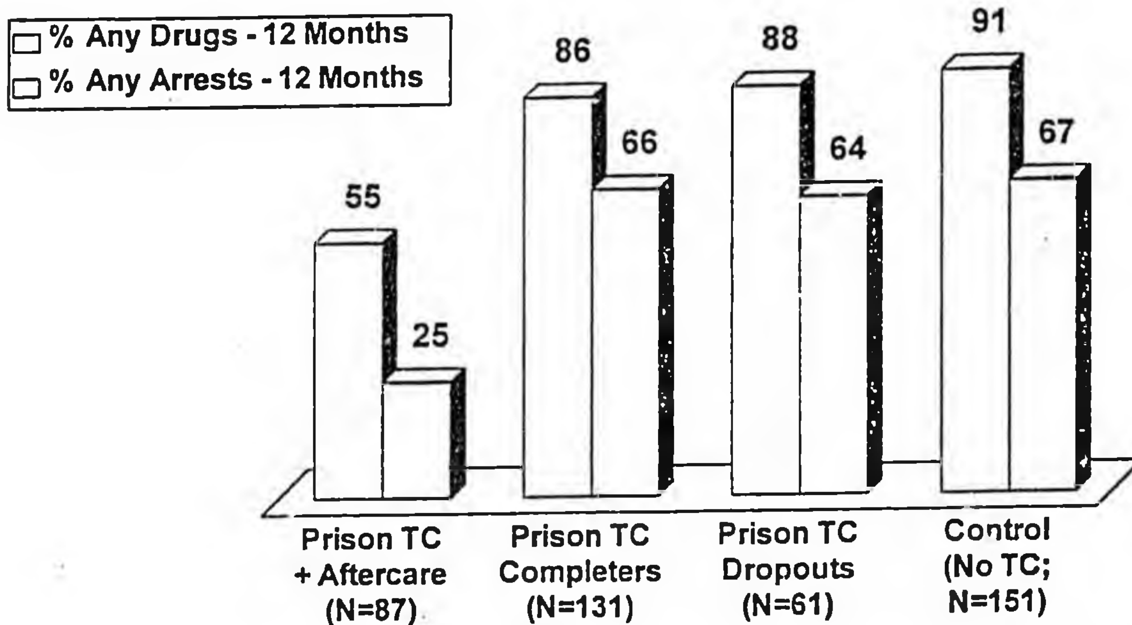
Delaware Therapeutic Continuum: 18-Month Outcomes

(J. Inciardi, U of Delaware, Feb 1997)



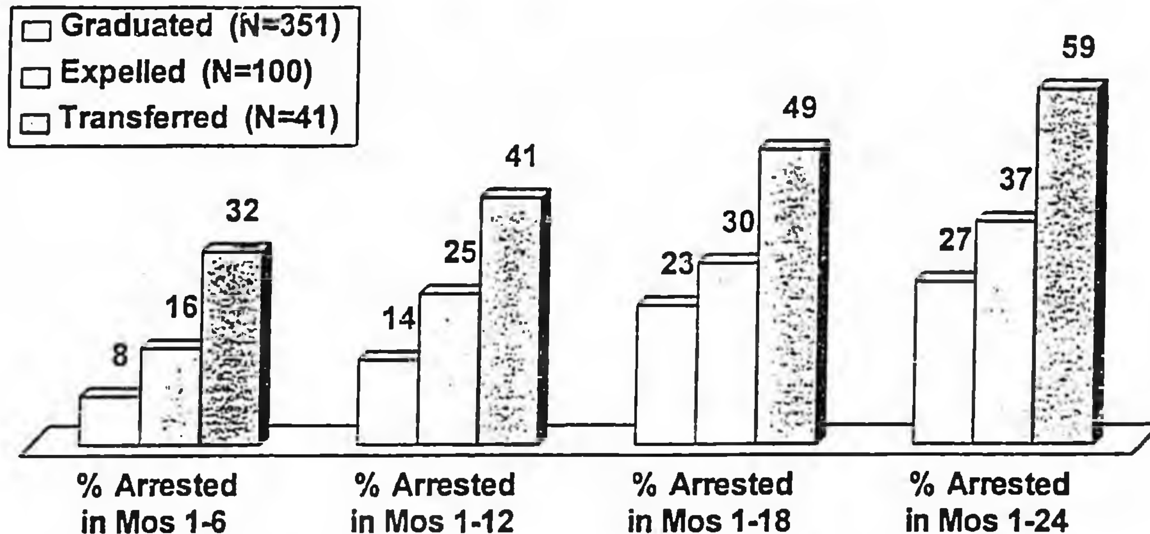
California/Amity Prison TC: 12-Month Outcomes

(H. Wexler, NDRI Inc., Feb 1997)



Dallas County Judicial Treatment Center (Wilmer): Treatment Follow-up Arrest Rates*

(K. Knight, M. Hiller, & D. Simpson, Texas Christian University)



[*Based on DPS Records]

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Treatment in criminal justice settings <u>can be effective!</u>

Recommendations

1. Require **6 months or longer** in treatment facility.
2. Use a **high-intensity** therapeutic approach.
3. Develop a **systematic screening and referral** system.
4. Require **community-based continuing care** after discharge.
5. Insure **assessment and evaluation** for accountability.

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The Effects of Intensive Treatment on Reducing the Criminal Recidivism of Addicted Offenders

BY GARY FIELD, PH.D.
Alcohol and Drug Services Manager, Oregon Department of Corrections

THE IMPACT of substance abuse on crime is profound. A 1974 Census Bureau study of 10,400 state prison inmates found that 39 percent of robberies, 47 percent of burglaries, 53 percent of homicides, and 61 percent of assaults were reported to be committed under the influence of alcohol (Roizen and Schneberk, 1977). A survey of 13,700 state prison inmates in 1986 found that 35 percent of inmates admitted using drugs at the time of their crime and that 43 percent reported using drugs on a daily or nearly daily basis within the month prior to committing the crime that led to their incarceration (Innes, 1988). According to a recent National Institute of Justice report on its Drug Use Forecasting System, 73 percent of male arrestees in 11 U.S. cities who voluntarily submitted urine samples tested positive for drugs (Wish, 1988). Individuals with established patterns of both drug abuse and criminality have been shown in studies in Baltimore and Los Angeles to have increases or reductions in criminality with corresponding increases or reductions in drug abuse (Gropper, 1984).

Effective treatment for addicted offenders can be part of the solution to the problems of reducing crime and turning offenders into productive citizens. The most effective treatment programs reported to date with addicted offenders have been intensive treatment programs of considerable duration that are designed as modified therapeutic communities. The Stay N' Out program in New York (Wexler, Falkin, and Lipton, 1988) and the Cornerstone program in Oregon (Field, 1985) have both reported substantial reductions in criminality by successfully treated inmates.

This article presents a followup study on reduction of criminal recidivism by inmates treated in the Cornerstone Program. It also presents methods for measuring changes in criminal activity over time that may be helpful to other researchers.

Program Description

The Cornerstone Program has been described extensively elsewhere (Field, 1985). The program is a 32-bed modified therapeutic community located on the grounds of Oregon State Hospital in Salem. Successful residents typically spend the last 10 to 12 months of their sentence in the program, are paroled directly from the program, and are provided with 6 months of aftercare/transitional services while they are on parole. Cornerstone is coeducational, but most of the program participants (95 percent) are male. The following treatment principles summarize the program's characteristics and style:

1. *Separating inmates from the general population.* State prison inmate cultures are antithetical to the environment that is needed for successful treatment. Inmate cultures value lying to authority, glamorizing drugs and crime, and an atmosphere of negativeness and nihilism. Hope for personal change has a difficult time surviving in this kind of context. The cultures of successful treatment programs center around peer support and pressure for personal change, rather than around an obsession with "fighting the system." The social environment of treatment is as important as the information presented.

2. *Clearly understood rules and consequences.* Inmates need to clearly understand what is not acceptable and what the consequences are for breaking rules. Inmates do better at managing themselves and learning new information or behaviors when clear limits are established and held to.

3. *A clear system for earning freedom a little at a time.* It is important for addicted inmates to earn privileges for behavior that supports their recovery and to lose privileges when they begin to relapse into criminal thinking or the early stages of addictive behavior. By this process, systematically managed, the inmates can best learn that they have control over their own lives.

4. *Formal participation by inmates in running the program.* Inmates need to feel "ownership" in the program to fully invest themselves in it. Responsibility for self is a key treatment goal, and inmates need to be given as much responsibility as they can manage.

5. *Intensive treatment.* Addicted inmates need a wide variety of treatment interventions as well as a full weekly schedule. Aside from these people needing habilitation or rehabilitation to a number of life skills, they do best when their days are fully structured and the demand level of what is expected of them is kept high.

6. *Treating addiction and criminality.* Both of these problems exist in the drug dependent inmate. If both are not simultaneously addressed, the untreated one will consistently undermine the other. That is, a criminal lifestyle tends to yield alcohol/drug abuse, and alcohol/drug abuse tends to yield a resurgence of criminal activity.

7. *Transition and aftercare.* Successful treatment needs to focus on helping the inmate prepare to return to the community. Community involvement should continuously expand during the course of treatment. Once paroled and relesed from residential treatment, parolees need continuing interventions to assure they are following their recovery plan

Program Population

Table 1 below lists some of the critical demographic characteristics of the Cornerstone population during this study. The data in table 1 are taken from the January 1984 population and are typical. The average number of adult felony convictions, average total time incarcerated as an adult, and the average age of first substance abuse document the extreme chronicity of criminality and substance abuse on this group.

TABLE 1. CHARACTERISTICS OF THE CORNERSTONE TREATMENT POPULATION GIVEN IN GROUP MEANS

Age	31.0
Age first arrest	13.6
No. of adult arrests	13.7
No. of adult felony convictions	6.9
Total time incarcerated as an adult	7 yrs., 7 mo.
Age of first substance abuse	12.5

Evaluation Design and Method

This is a criminal recidivism study done retrospectively using the Law Enforcement Data System (LEDS), a computerized telecommunications and information system for Oregon law enforcement agencies that lists criminal activity for Oregon and accesses the Federal criminal justice data system.

The 220 unduplicated program discharges from January 1, 1983, through December 31, 1985, were sorted into four experimental groups: Program graduates (Grads) (N=43); non-graduates who spent more than 6 months in the program (NG>6 mo.) (N=43); non-graduates who spent more than 2, but less than 6 months in the program (NG 2-6 mo.) (N=58); and non-graduates who spent between 1 day and 2 months in the program (NG 0-2 mo.) (N=65). Six of the potential NG 2-6 mo. group had to be eliminated from the study because four were deceased and two had failed to be released from prison since leaving the program. Five potential NG 0-2 mo. group members had to be eliminated because they were in the program so short a time (less than 1 day) that adequate identifying information had not been collected by program staff. The remaining 209 subjects were distributed throughout the four experimental groups as noted above.

The dependent variables in this study were arrests, convictions, and prison incarcerations. Arrests were tabulated as "arrest events" as reported in LEDS. These "arrest events" may have included multiple arrest "counts" at the time of arrest. Similarly, convictions were tabulated on the basis of each "arrest event" and did not consider convictions on multiple "counts." Therefore, only one tabulated conviction was possible for each "arrest event." Arrests and convictions included all recorded arrests and convictions: misdemeanors as well as felonies. County jail time actually spent (as opposed to suspended sentences) exceeding 6 months (more than 179 days) on a conviction was counted as equivalent to a state prison incarceration. County jail time of less than 6 months actual duration, along with fines and probation, were considered as convictions without prison incarceration.

In the first part of the study, absence of any arrests, convictions, and prison time for 3 years after the beginning of parole was compared across all four experimental groups.

In the second part of the study, rates of arrest, conviction, and prison incarceration were compared across the groups for a "3-year" interval after parole and for two "3-year" intervals before incarceration for the offense that led them to the Cornerstone Program. The "3-year" intervals are actually "36-month at-risk intervals," because each of these time periods included a complete 36 months without incarceration time. So if, for example, after 12 months into an interval an individual was incarcerated for 4 months, the actual interval would be extended for 4 months (from 36 to 40). This method creates a full 36-month "at-risk" time interval of study and is a more accurate measure of frequency of criminal activity.

Two problems were encountered with the rate study. Some subjects had not spent sufficient time out of prison since entering treatment (at least 1 year) to have achieved measurable rates of arrest, conviction, and incarceration and had to be dropped from the second part of the study. Other subjects were too young to have had at least three complete years of non-incarcerated time since their 18th birthday. These people were also dropped from the second part of the study. Final numbers for the second part of the study were as follows:

Grads	43 of 43 - 100 percent
NG >6 mo.	37 of 43 - 86 percent (1 subject too young, 5 had not been out of prison one full year post treatment)
NG 2-6 mo.	41 of 58 - 71 percent (5 too young, 12 not out of prison one full year post treatment)
NG 0-2 mo.	37 of 65 - 57 percent (9 too young, 16 not out of prison one full year post treatment, 3 still on escape status)

In each of the experimental groups, about 75 percent of the subjects were old enough to have at least 6 years of "at risk" community time. These are the subjects that were used to gather the data for the 3- to 6-year pre-treatment interval.

Results and Discussion

Table 2 presents absence of arrests, convictions, and prison incarcerations for 3 years after parole for Cornerstone graduates (average stay of 11 months), non-graduates who stayed in the program for more than 6 months (180 days), non-graduates who stayed 2-6 months (60 - 179 days), and non-graduates who stayed less than 60 days.

TABLE 2. RATES OF AVOIDING ANY ARREST, CONVICTION, OR PRISON TIME FOR 3 YEARS AFTER PAROLE FOR CORNERSTONE PARTICIPANTS FROM 1983 THROUGH 1985

	No Arrests	No Convictions	No Prison Time
Program Graduates (Grads) (N=43)	37%	51%	74%
Non-Grads who completed at least 6 months (NG>6 mo.) (N=43)	21%	28%	37%
Non-Grads who completed 2 through 5 months (NG 2-6 mo.) (N=58)	12%	24%	33%
Non-Grads who left before 60 days (NG 0-2 mo.) (N=65)	8%	1[illegible]%	15%

The order of success as measured by no arrests, convictions, or prison incarcerations in table 2 consistently favors time in treatment. Program graduates consistently do much better than the non-graduate groups, even though many graduates continue to have some contact with the criminal justice system. The two "partial treatment" groups (2 to 6 months and more than 6 months groups) show results that are similar to one another, but again consistently favor time in treatment. The less than 60 day group comes close to being a no-treatment comparison group. The poor results shown by this group without significant treatment are noteworthy.

The consistent ordering of success rates and the constancy of relative success between the groups across arrest, conviction, and prison incarceration data suggest that any of these three dependent variables are an equally usable outcome measure.

Because simple presence or absence of arrests, convictions, or prison incarceration over a lengthy time period hides much of the criminal activity that is occurring, it was decided to measure rates of each of these outcome variables. By comparing post treatment rates with pre-treatment rates, it was hoped that a clearer picture of the effects of intensive treatment would be gained.

Figure 1 presents arrest rates for the four experimental groups over pre and post treatment 3-year at risk intervals. Figures 2 and 3 present the same data for convictions and prison incarcerations.

The data presented in all three figures are remarkably similar. In each case the four experimental groups are virtually identical at the pre-treatment intervals. In each case all four groups show accelerating criminal activity across the pre-treatment intervals. In each case the relatively untreated (NG 0-2 mo.) show a continuation of accelerating criminal activity following their brief exposure to intensive treatment. Finally, in each case the treated groups show a decrease in criminal activity that correlates positively with time in treatment. As in the first part of the study, program graduates do significantly better than non-graduates.

These results present a more thorough and graphic display of the effects of intensive treatment on reducing criminal recidivism among addicted offenders than was possible from the data in table 2.

This study has two obvious limitations. First, subject motivation for change is not controlled for across the experimental groups. Some of the positive effects may have occurred because those inmates who stayed in treatment were simply more motivated, rather than the results being due to specific treatment effects. There are two counterbalances to this study limitation. First, subject motivation at some point is always a part of successful treatment, and second, no motivational differences between the groups are apparent in the pre-treatment data in figures 1, 2, or 3.

The second limitation in this study occurred because the complexity and requirements of mea-

FIGURE 1. GROUP MEAN ARREST RATES OVER PRE AND POST TREATMENT 3-YEAR "AT RISK" INTERVALS

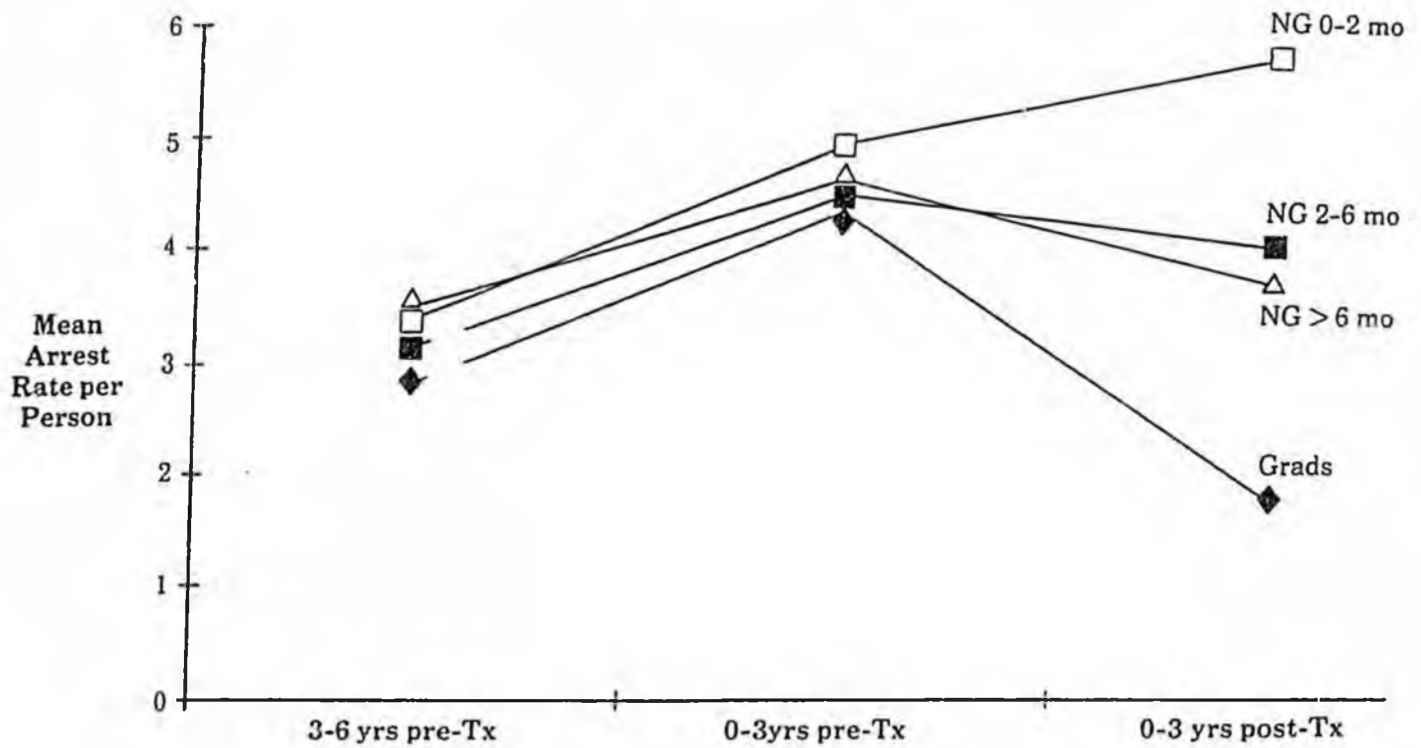


FIGURE 2. GROUP MEAN CONVICTION RATES OVER PRE AND POST TREATMENT 3-YEAR "AT RISK" INTERVALS

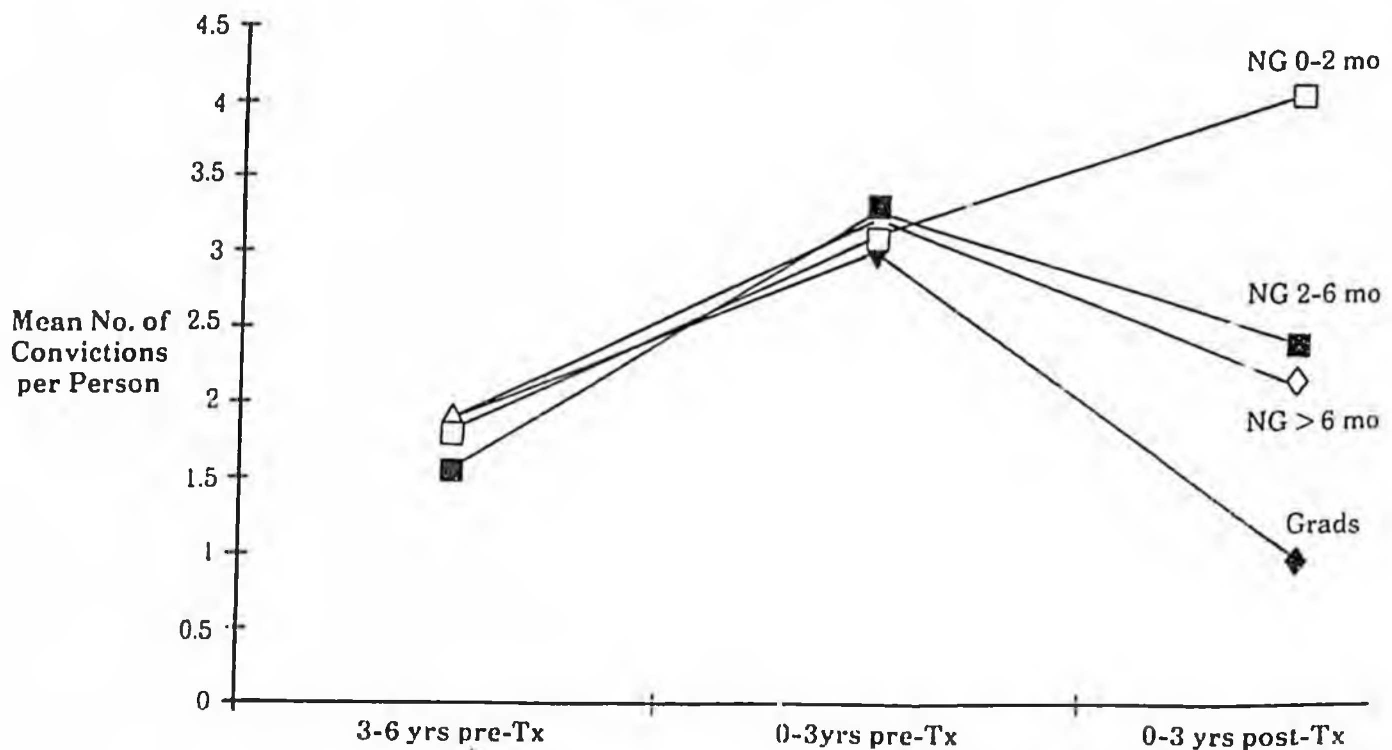
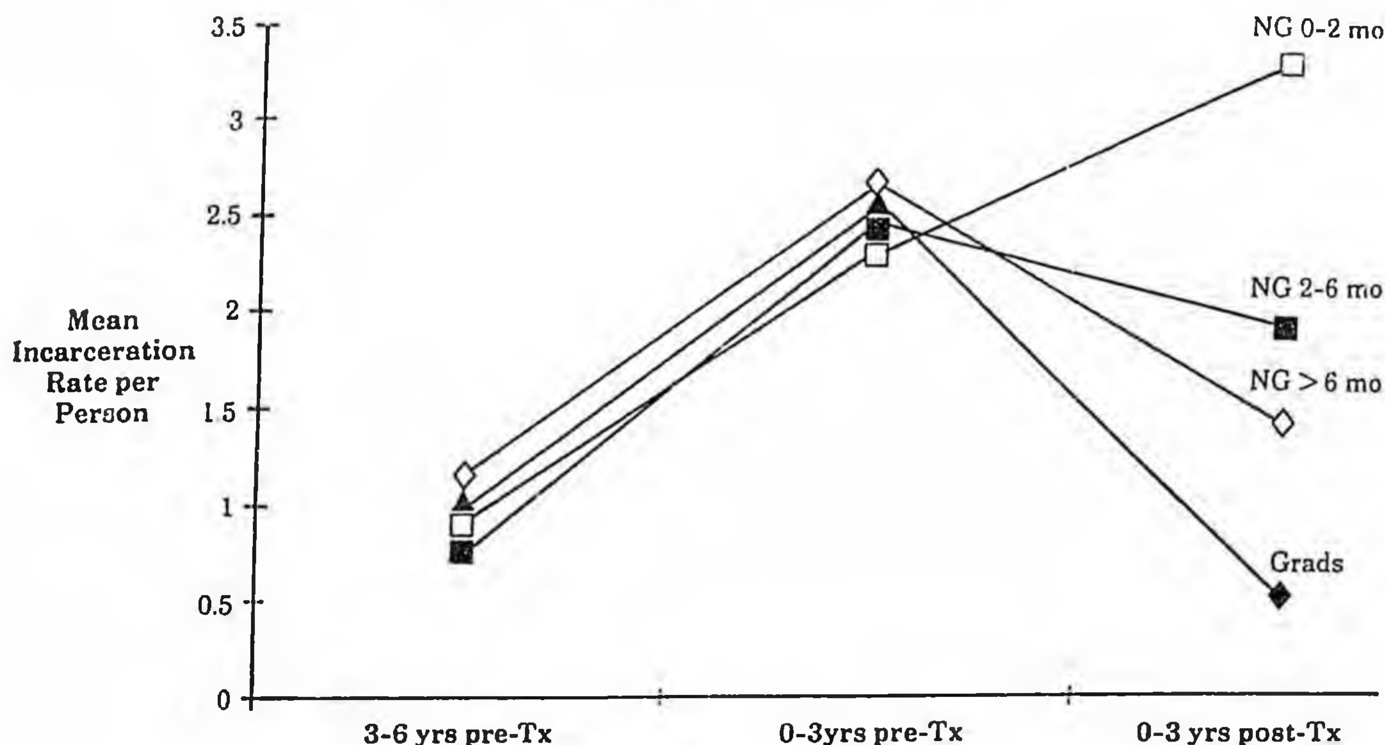


FIGURE 3. GROUP MEAN INCARCERATION RATES OVER PRE AND POST TREATMENT 3-YEAR "AT RISK" INTERVALS



suring pre and post treatment arrest, conviction, and prison incarceration rates necessitated that significant numbers of subjects in some of the groups be dropped from part of the study. The question is what biasing factor occurred by dropping those subjects from the second part of the study? That question cannot be answered with any certainty at this time. However, the subjects who were dropped from the non-graduate groups were dropped largely because they had recidivated at such a rate that they had not yet achieved 12 full months of community time in the 3 to 5 years since their parole. These individuals, therefore, probably represent the "worst cases" in the non-graduate groups and would likely push the arrest, conviction, and incarceration rates at post treatment even further apart creating even more separation between the experimental groups.

Conclusions

The following conclusions are drawn from the results of this study.

1. The Cornerstone Program continues to demonstrate a positive effect on decreasing the criminal activity of program participants.

2. Addicted offenders who receive little or no treatment show an accelerating pattern of criminal activity over time.

3. Time in treatment in an intensive treatment program for addicted offenders correlates positively with measured decreases in criminal activity.

4. Many successfully treated addicted recidivist offenders continue to show at least some involvement with the criminal justice system after treatment, even though their involvement is reduced.

5. Arrests, convictions, or prison incarcerations all seem to be approximately equally accurate measures of criminal activity.

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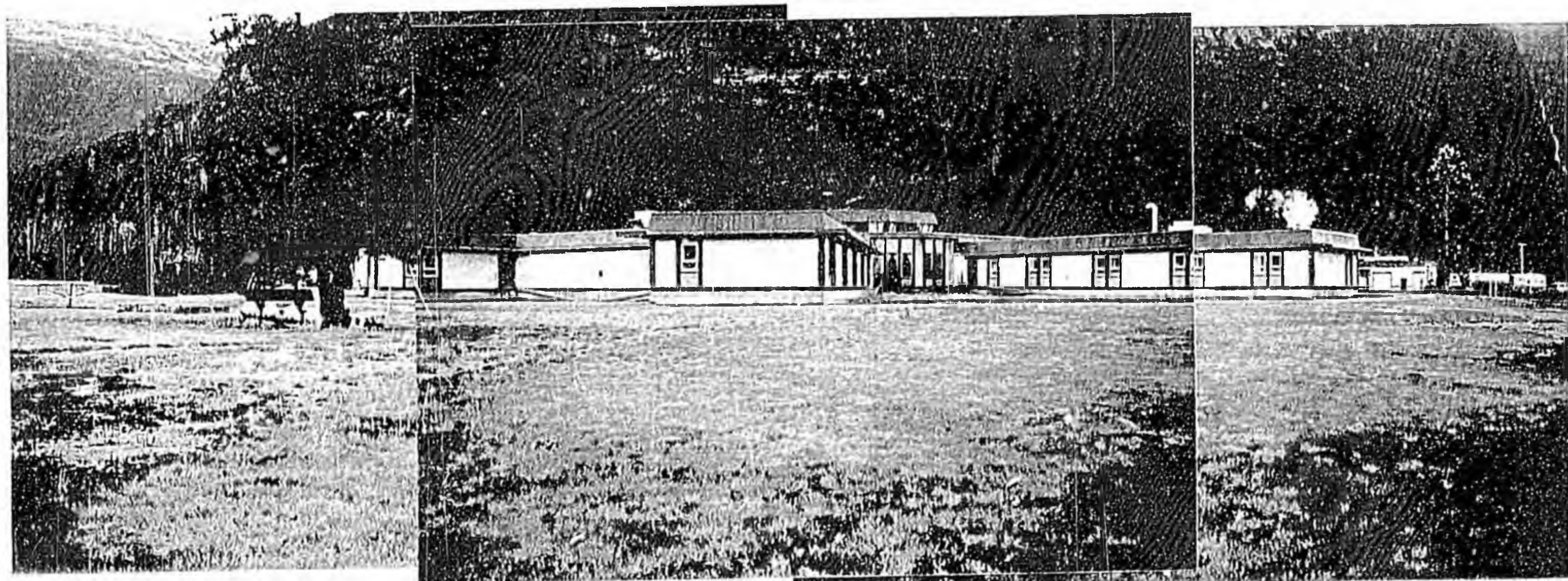


Valdez Therapeutic Community

Benefits of the Valdez Therapeutic Community

The addition of sixty beds at the Valdez Therapeutic Community will help in addressing DOC's overcrowding.

- The facility will house minimum to medium custody prisoners who are actively involved in intensive treatment.
- The completion of this six to ten month program, which will address the needs of inmates with serious chemical dependency problems, will enhance their eligibility for furlough or parole.
- When inmates who need this type of treatment receive it before release, and are carefully transitioned into the community, it is reasonable to expect a significant reduction in recidivism and the repeated use of a "hard bed".

The Valdez Therapeutic Community offers an opportunity to provide comprehensive treatment to Alaska's most seriously addicted inmates.

- The program will be culturally relevant, incorporating an awareness of the Native life-style and history in Alaska. Treatment techniques and activities will be reflect and respect Native values.
- The Department of Corrections offers the following levels of care in its institutions: substance abuse education, introduction to treatment, and institutional outpatient treatment. The Valdez Therapeutic Community will complete the continuum of care in the institutions by providing residential treatment.
- Transitional care will be a priority in the treatment plans of every inmate participating in the Valdez Therapeutic Community. Housing, employment and/or education, outpatient counseling and the linkages with community support systems will be established before release.

Alaska's communities will be safer if seriously addicted inmates receive intensive residential treatment in a therapeutic community before they are released.

- The target population for the Valdez Therapeutic Community is the inmate who has a history of substance abuse related criminal activity.
- An evaluation component is being built into the program design. The outcome study will link time spent in treatment with criminal recidivism.

Steps Taken to Prepare for the Valdez Therapeutic Community

- The Inmate Substance Abuse Program Counselors have canvassed the inmate population across the state for their need for a therapeutic community on three separate occasions.

- The Department of Corrections has established communication with the City of Valdez and other citizens, regarding the implementation of a therapeutic community.

- The Department of Corrections has the support of the Valdez Police Department in addressing public safety issues.

- The Department of Corrections, in coordination with the City of Valdez, has conducted an architectural planning and program analysis to establish a plan for the best utilization of space for program and security needs.

- The Department of Corrections is eligible for federal Residential Substance Abuse Treatment (RSAT) grants, under the auspices of the U.S. Department of Justice, to be applied to the treatment at the therapeutic community.

- Technical assistance through RSAT has been designated for program design, including transitional care, team building with treatment and security staff, and the development of an outcome study.

- The Department of Corrections is receiving technical assistance from Dr. Gary Field through the Federal RSAT Program.

- The Department of Corrections has studied existing correctional therapeutic communities across the U.S. to learn the elements that make such a program successful. We will continue to stay current with research and design.

Other Pertinent Information:

- The 1997 Annual Report by the Advisory Board on Alcoholism and Drug Abuse includes the results of survey responses of 521 key informants throughout Alaska. Ninety-six percent (96%) of the respondents agree that "those incarcerated for criminal offenses related to the abuse of alcohol or other drugs should receive appropriate treatment before release from prison."

Institutions Inmate/Day Cost Comparison
Institutional Costs
(Based on FY97 Actual Operating Costs)

Institution	Annual Cost	Actual Mandays	Institution Costs	Inmate Programs	Inmate Hlth Care	Div.of Admin & Support	Statewide Indirect	* Total	Total Less Treatment
Anvil Mountain CC	$3,949,505.26	38,325	$103.05	$3.78	$13.61	$4.51	$5.23	$130.18	
Cook Inlet CC	$9,319,457.68	154,030	$60.50	$3.78	$13.61	$4.51	$5.23	$87.63	
Fairbanks CC	$6,941,227.48	83,950	$82.68	$3.78	$13.61	$4.51	$5.23	$109.81	
Hiland/Meadow Creek CC	$7,439,282.78	108,405	$68.62	$3.78	$13.61	$4.51	$5.23	$95.75	
Ketchikan CC	$2,631,099.44	20,440	$128.72	$3.78	$13.61	$4.51	$5.23	$155.85	
Lemon Creek CC	$6,024,682.75	73,365	$82.12	$3.78	$13.61	$4.51	$5.23	$109.25	
Matanuska-Susitna CC	$2,797,812.41	33,580	$83.32	$3.78	$13.61	$4.51	$5.23	$110.45	
Palmer CC	$8,812,224.76	148,190	$59.47	$3.78	$13.61	$4.51	$5.23	$86.60	
Sixth Avenue CC	$3,903,571.63	49,640	$78.64	$3.78	$13.61	$4.51	$5.23	$105.77	
Spring Creek CC	$13,807,974.25	191,625	$72.06	$3.78	$13.61	$4.51	$5.23	$99.19	
Wildwood CC	$8,212,656.94	123735	$66.37	$3.78	$13.61	$4.51	$5.23	$93.50	
Yukon-Kuskokwim CC	$3,924,580.19	40,880	$96.00	$3.78	$13.61	$4.51	$5.23	$123.13	
Current Statewide Average	$77,764,076.67	1,066,165	$72.94	$3.78	$13.61	$4.51	$5.23	$100.07	
Proposed Harborview Therapeutic *	$1,858,900.00	21,900	$84.88	$28.49	$10.68	$0.31	$0.00	$124.36	$95.97
Harborview Therapeutic Community	$1473.7 + $385.2	na	na	$624.0	$234.0	$6.8	$0.0	$2,723.7	

Legislative Intent: HCS CSSB 107(FIN) am H, Chapter 100 SLA 97 Section 74 (a) :

" The sum of $400,000 is appropriated from the federal receipts crime funds to the Department of Corrections for a therapeutic treatment community program of up to 100 beds in Valdez where costs per inmate day (exclusive of treatment costs) will not exceed the statewide average cost per day for correctional institutions."

Institutions calculated based on FY97 actuals @ 9/1/97

3/6/98

Research Summary

Special Issue | IBR Web Site: www.ibr.tcu.edu | April 1997

Facts About Legal Offenders!*

- 60-85% have used illicit drugs (based on UAs for arrestees and prison surveys)
- 45% of arrestees for violent or property crimes test positive for drugs
- 33% of state prison inmates have committed drug offenses
- Active drug use increases crime rates by a factor of 4 to 6 times

"A logical, cost-effective, and convenient point of intervention is the time they are in custody." (Lipton, 1995, pg. 5)

However, only about 1 of 10 U.S. prisoners receive any form of drug treatment.

---

*Lipton, D. S. (November, 1995). *The Effectiveness of Treatment for Drug Abusers under Criminal Justice Supervision.* National Institute of Justice.

*Lipton, D. S. (February, 1996). Prison-based therapeutic communities: Their success with drug-abusing offenders. *National Institute of Justice Journal*, 12-20.

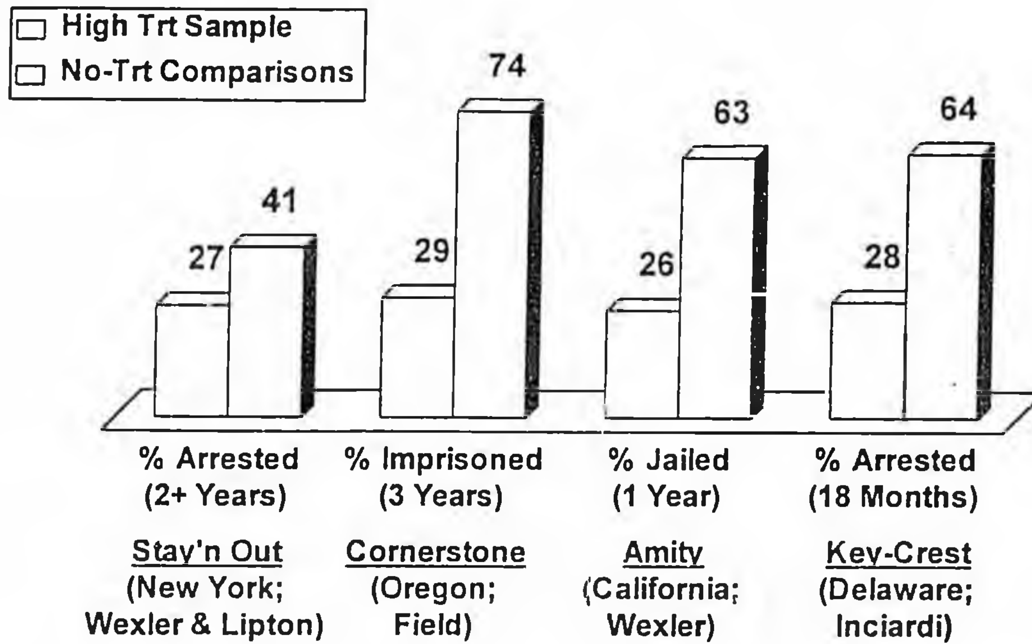
Research Focus of the IBR at TCU

For many years, research staff of the IBR have given special attention to evaluations of substance abuse and behavioral interventions provided by community-based programs, including prevention and treatment and to the study of long-term addiction careers. Research interests have broadened in recent years to include related areas of significant public concern, such as drug abuse treatment in criminal justice settings as well as the spread of AIDS among injecting drug users and methods for reducing these and other high-risk behaviors.

IBR Director: D. Dwayne Simpson, Ph.D., *Associate Director:* Lois R. Chatham, Ph.D.;
Manager of Criminal Justice Studies: Kevin Knight, Ph.D.

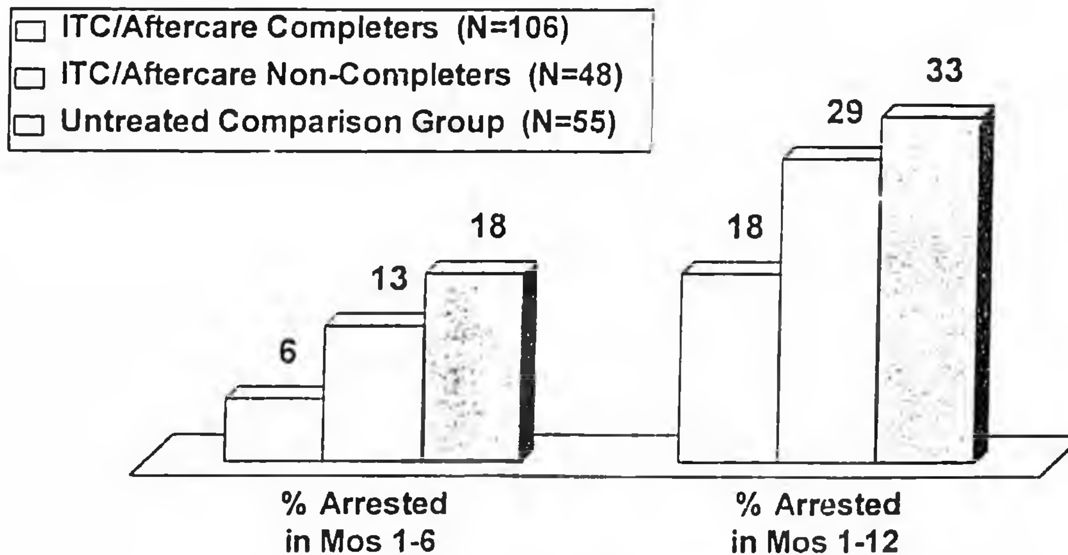
Outcome Studies of Prison-Based Treatment

(Lipton, 1996)



Texas In-Prison Therapeutic Community (ITC) Treatment: 12-Month Arrest Rates*

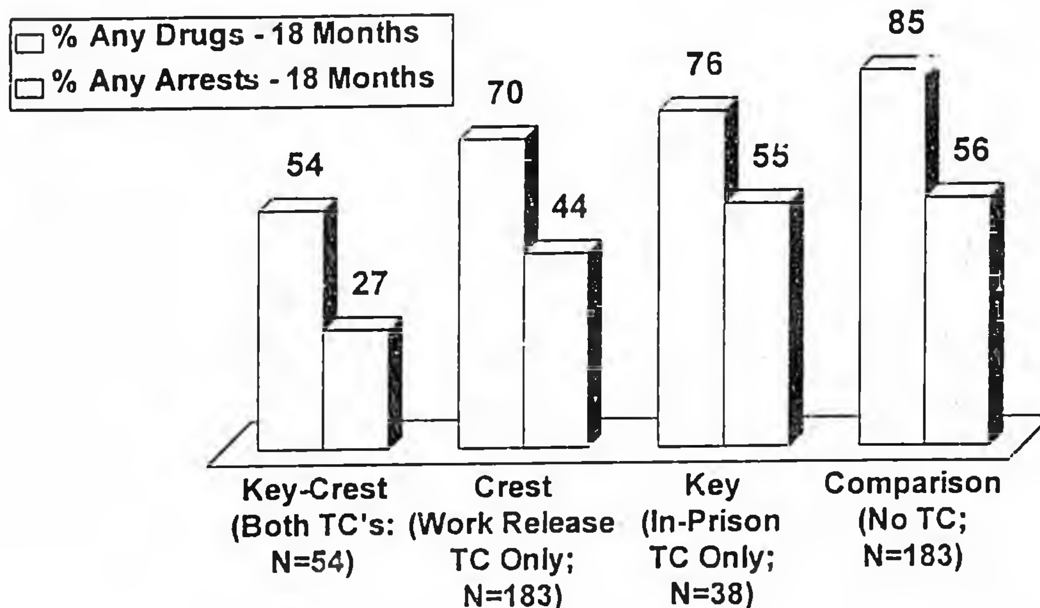
(D. Simpson & K. Knight, Texas Christian University)



[*Based on DPS and Parole Officers Records]

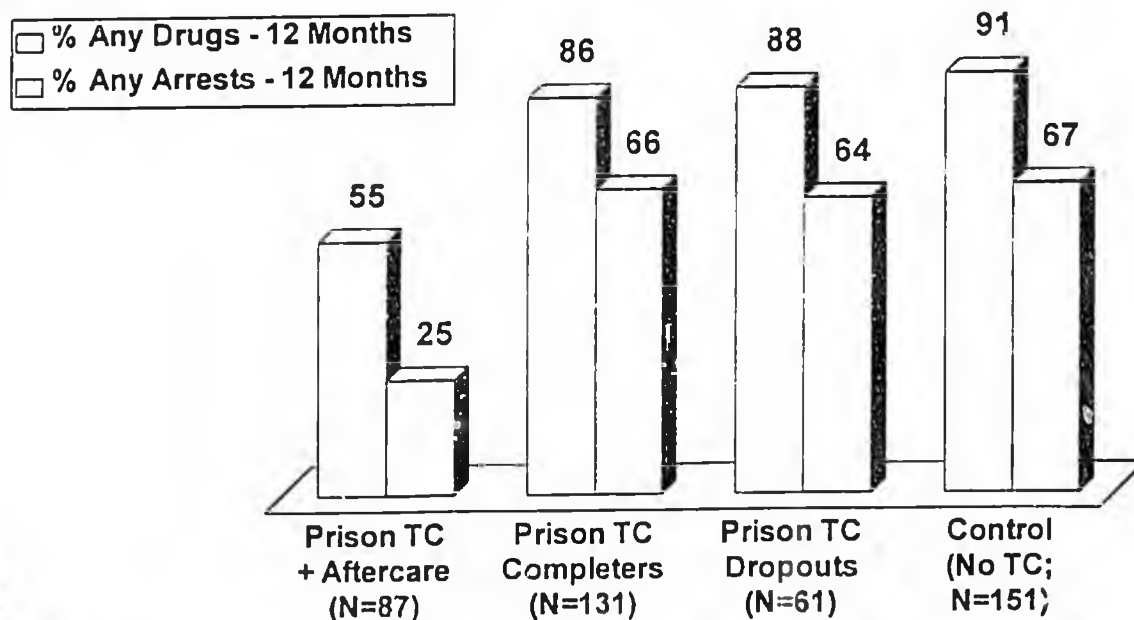
Delaware Therapeutic Continuum: 18-Month Outcomes

(J. Inciardi, U of Delaware, Feb 1997)



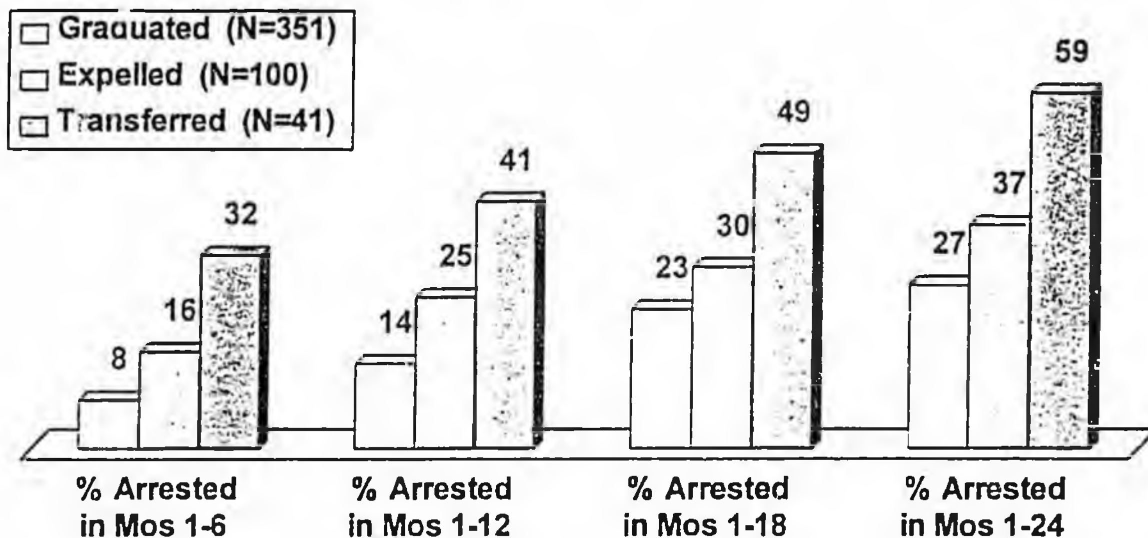
California/Amity Prison TC: 12-Month Outcomes

(H. Wexler, NDRI Inc., Feb 1997)



Dallas County Judicial Treatment Center (Wilmer): Treatment Follow-up Arrest Rates*

(K. Knight, M. Hiller, & D. Simpson, Texas Christian University)



[*Based on DPS Records]

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Treatment in criminal justice settings can be effective!

Recommendations

1. Require **6 months or longer** in treatment facility.
2. Use a **high-intensity** therapeutic approach.
3. Develop a **systematic screening and referral** system.
4. Require **community-based continuing care** after discharge.
5. Insure **assessment and evaluation** for accountability.

This special issue of ***RESEARCH ROUNDUP*** is published by the Institute of Behavioral Research, Texas Christian University. (817) 921-7226; FAX: (817) 921-7290; E-mail: ibr@tcu.edu; Web: www.ibr.tcu.edu
Prepared by Dwayne Simpson, Kevin Knight, and Charlotte Pevoto.

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No: 1

FISCAL NOTE

Bill Version: HB 329
(H) Publish Date: 1/16/98

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Revision Date: (Note if correction)
Title: "An Act amending the definition of correctional facility to include a therapeutic treatment center...."
Sponsor: Rules Committee
Requestor: Governor

Department Affected: Administration
BRU: General Services
Component: Purchasing

COMPONENT SERIAL NO. 60

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 98) cost: $ none

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.) The bill authorizes transfer of excess real property and improvements of the Harborview Development Center in Valdez to the City of Valdez. Under the terms of the transfer, the City of Valdez must agree to convert a portion of the facility to a therapeutic treatment center and lease it to the Department of Corrections. Up to 60 inmates qualifying for therapeutic treatment would be housed in the treatment facility. The fiscal note is based on the following assumptions:

1. All funds necessary to complete improvements are with either the City of Valdez and/or the Department of Corrections.
2. Transfer of the property occurs on June 30, 1998.
3. No monetary consideration is received at transfer.
4. Funding for payment of the lease and all other operating costs is with the Department of Corrections.

Prepared by: Dugan Petty, Director
Division: General Services
Phone: 465-2250
Date:

Approved by Commissioner: Mark Boyer
Agency: Department of Administration
Date: 1/7/97

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FISCAL NOTE

No: 2

STATE OF ALASKA
1998 LEGISLATIVE SESSION

B. Version: HB 329
(H) Publish Date: 1/16/98

Revision Date:
Title: An act amending the definition of correctional facility to include therapeutic... ...
Sponsor: Rules Committee
Requestor: Governor's Office

Dept. Affected: Health and Social Services
BRU: Administrative Services
Component: Health Planning and Facilities Managemen
COMPONENT SERIAL NO. 2020
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts	0.00	0.00	0.00	0.00	0.00	0.00
1003 GF Match	0.00	0.00	0.00	0.00	0.00	0.00
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS:

	FY99	FY00	FY01	FY02	FY03	FY04
FULL-TIME	none	none	none	none	none	none
PART-TIME	none	none	none	none	none	none
TEMPORARY	none	none	none	none	none	none

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

After conveyance of Harborview, the City of Valdez would then lease back a portion of Harborview to the Department of Corrections for a therapeutic drug and alcohol program for Alaska inmates. If the Legislature does not fund the therapeutic treatment center program, the City of Valdez won't be able to takeover ownership of the Harborview facility. That would mean that the Harborview facility would remain in State ownership with the Department of Health and Social Services. Effective July 1, 1998 the Department of Health and Social Services has no operating funds to operate the Harborview facility in the Asset Protection mode. It is estimated that annual operating costs for Harborview after July 1, 1998 in the Asset Protection mode (one maintenance person, utility and heating costs, etc.) would be approximately $265 thousand dollars.
There is one further complication. The City of Valdez has expressed concern that if the Legislature fails to appropriate funds for the Department of Corrections therapeutic treatment program, the Valdez Community Hospital, located in the Harborview building, could close, resulting in serious health care implications for the local community.

5/18

Prepared by: Janet Clarke
Division: Administrative Services
Phone: 465-3015
Date: 01/08/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1/12/98

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FISCAL NOTE

STATE OF ALASKA **BILL NO.** HB329

1998 LEGISLATIVE SESSION

Revision Date:
Title: An Act amending the definition of correctional facility to include a therapeutic treatment center; ...
Sponsor: House Rules Committee
Requestor: (H)STA

Dept Affected: Natural Resources
BRU: Resource Development
Component: Land Development
Component Serial No. 431

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES (fund code)	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost: $ none

POSITIONS

POSITIONS	FY99	FY00	FY01	FY02	FY03	FY04
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: *(Attach a separate page if necessary)*

There is no anticipated additional fiscal impact for the Department of Natural Resources as a result of passage of this legislation.

Rec 4:30
3/6/98

Prepared by: Jane Angvik, Director [signature] Phone : 269-8503
Division: Land Date : 6-Mar-98
Approved by Commissioner: [signature] for [signature] Date: 3-6-98
Agency: Natural Resources

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Bill Version: HB 329
(H) Publish Date: 1/16/98

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Revision Date:
Title: An Act amending the definition of correctional facility to include a therapeutic treatment center; ...
Sponsor: Rules Committee
Requestor: Governor Knowles

Dept Affected: Natural Resources
BRU: Resource Development
Component: Land Development
Component Serial No. 431

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES (fund code)	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

Fund Source	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost: $ none

POSITIONS

Positions	FY99	FY00	FY01	FY02	FY03	FY04
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: *(Attach a separate page if necessary)*

There is no anticipated additional fiscal impact for the Department of Natural Resources as a result of passage of this legislation.

Prepared by: Jane Angvik, Director
Phone: 269-8503
Division: Land
Date: 8-Jan-98
Approved by Commissioner:
Date: 1/12/98
Agency: Natural Resources

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No: 4

Bi" Version: HB 329
(H, ?ublish Date: 1/16/98

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Revision Date (Note if correction)
Dept. Affected: Corrections
Title: An Act amending the definition of a correctional facility to include a therapeutic treatement center;...
BRU: Administration and Operations
Component: Office of the Commissioner
Sponsor: Rules Committee
Requester: Governor
Component Serial No. #0694

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Personal Services	787.3	1,049.7	1,049.7	1,049.7	1,049.7	1,049.7
Travel	49.5	22.0	22.0	22.0	22.0	22.0
Contractual	1,326.4	1,533.0	1,535.7	1,538.4	1,541.1	1,543.9
Supplies	131.5	87.0	87.0	87.0	87.0	87.0
Equipment	141.5	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	24.0	32.0	32.0	32.0	32.0	32.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	2,460.2	2,723.7	2,726.4	2,729.1	2,731.8	2,734.6
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
1002 Federal Receipts	133.9	133.9	0.0	0.0	0.0	0.0
1003 GF Match	44.6	44.6	0.0	0.0	0.0	0.0
1004 GF	2,281.7	2,545.2	2,726.4	2,729.1	2,731.8	2,734.6
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	2,460.2	2,723.7	2,726.4	2,729.1	2,731.8	2,734.6

Estimate of any current year (FY98) cost: 0.0

POSITIONS

POSITIONS	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Full-time	18	18	18	18	18	18
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The Valdez Therapeutic Community will be a sixty bed, six to ton month intensive residential substance abuse treatment program for minimum and medium custody level prisoners within the DOC. Male prisoners will be referred from Alaska's correctional institutions around the state. The DOC will maintain security while a contracted treatment provider will be responsible for delivery of the treatment program.

This fiscal analysis assumes that facility operations will start on 10/1/98 of FY99 and only incur 3 quarters of operational costs during that fiscal year. FY99 and FY00 Federal Funds are based on a limited two year Federal RSAT Grant which requires a 33% GF Match. FY99 also includes all one-time "Start Up" costs associated with Medical, Treatment, Administrative D&WP, and Correctional operations (e.g., library, clothing, bedding, furniture, correctional equipment, etc.) Program Evaluation will be funded through the Federal RSAT grant with technical assistance provided by the Office of Justice Programs. This fiscal note does not contain inflationary costs except for a 2% Cost Index increase on annual lease payments. (Continued)

Prepared by: Dwayne Peeples, Director
Phone: 465-3339
Division: Administrative Services
Date: 1/15/98
Approved by: Commissioner Margaret M. Pugh *Margaret M. Pugh*
Date: 1-15-98
Agency: Department of Corrections

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HB 329.

Fiscal Note
Valdez Therapeutic Community
Page 2

Costs Featuring 60 Inmates:

	Start-Up Costs (FY99 One Time)	On-Going Annual Costs	
Inmate Health /Medical	$20.0	$234.0	
Inmate Programs/Treatment	$61.3	$624.0	
Design & Outcome	$40.0*	$0.0	
Admin. Services/D&WP	$40.0	$6.8	
Institution Operations	$162.4	$1,473.7	
DOA/GSS	$0.0	$385.2	2% CPI Increase Annually
TOTALS	$323.7	$2,723.7	

Operating Costs:

		FY99	Annually FY00-FY04	Notes
Institutions/Operating				
	Pers.Svcs	$649.3	$865.7	15 PFT Staff Personal Services
	Travel	$49.5	$22.0	FY99 Includes $33.0 start up funds
	Contractual Svcs	$353.3	$467.0	Includes $360.0 for Food Contracts
	Supplies	$104.9	$87.0	FY99 Includes $ 39.6 start up funds
	Equipment	$86.8	$0.0	FY99 Includes $ 86.8 start up funds
	Grants	$24.0	$32.0	Inmate Gratuities/wages
	Total	$1,267.8	$1,473.7	
Inmate Health Care				
	Pers. Svcs	$138.0	$184.0	3 PFT Staff Personal Services
	Contractual Svcs	$37.5	$50.0	On-call Doctor Services
	Supplies	$20.0	$0.0	Pharmacy & Medical start up
	Total	$195.5	$234.0	
Inmate Programs				
	Contractual Svcs	$508.0	$624.0	Treatment (11 contract positions)
	Supplies	$6.6	$0.0	Office Supplies
	Equipment	$54.7	$0.0	Furniture, PCs, Cabinets, etc.
	Total	$569.3	$624.0	
Administrative Services/Data & Word Processing				
	Contracts	$45.1	$6.8	Establish Netwo[illegible] System
	Total	$45.1	$6.8	
DOA/General Services & Supply				
	Leasing	$382.5	$385.2	2% CPI Increase Annually FY00-FY04
	Total	$382.5	$385.2	
	Grand Total	**$2,460.2**	**$2,723.7**	

*Note: Program evaluation funded with RSAT grant.