Criminal Justice and the Drug-Abusing Offender: Policy Issues of Coerced Treatment

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Criminal justice populations, including arrestees, probationers, inmates and parolees, have become increasingly involved with drugs of abuse. These numbers have seriously impacted the criminal justice system from enforcement to the courts, corrections, and subsequent legal supervision agencies. Prevalence of substance abuse in these populations is reported, as well as the effectiveness of community-based and corrections-based treatment in effecting behavioral changes to reduce drug demand. The characteristics of successful intervention programs are described and an ideal model proposed for better integrating community treatment and criminal justice intervention efforts.

Drug abuse and its consequences persist as a pernicious social problem in the United States. Drug-related criminal activity is at an all-time high, with homicides thought to be related to drug dealing increasing in cities across the country. According to the 1989 White House report on National Drug Control Strategy, three-fourths of all robberies and half of all felony assaults by young people are committed by drug users. Felony convictions in drug cases account for the largest and fastest growing sector of the federal prison system, a system already strained by overcrowding (The White House, 1989). Illicit drugs are detected in the urine of 40 to 90% of arrestees, depending on location, according to the National Institute of Justice's Drug Use Forecasting Program (Wish & Gropper, 1990). Studies of prison inmate populations indicate that 40 to 80% report histories of substance abuse (Petersilia, Greenwood, & Lavin, 1978; Innes, 1988).

The consequences of illicit drug use extend beyond criminal activity, actually posing a threat to American public health. Intravenous drug use has become the largest single source of new infections of HIV, and an increasing proportion of AIDS deaths are attributable to drug use. Other health morbidity indicators are also on the rise. Emergency room admissions related to drug abuse increased by 121%
between 1985 and 1988. The social costs of drug abuse include subsidized treatment and medical care of drug abusers, as well as special programs required for children who suffer health or cognitive impairment by in utero exposure to drugs (Goldstein & Kalant, 1990). The White House report estimated that as many as 200,000 babies are born each year to mothers who use drugs.

When drug abuse is viewed in light of its extensive social costs, there is clearly a pressing need for action to reduce levels of drug use. Thus, we have "the war on drugs" emerging from an atmosphere of desperation that is not conducive to sound policy making or effective legislation. Measures must be taken to counter the trends of drug abuse but these must be derived from careful, considered planning and implementation:

If we strike the right balance in drug policies . . . , it should be possible to bring about a reduction in demand for psychoactive drugs. A reduced demand for drugs offers the only real hope of eventually achieving, not a drug-free society, but one with substantially less drug abuse (Goldstein & Kalant, 1990).

A broad consensus is growing that the best way to achieve a reduction in drug demand is through a combination of prevention efforts for nonusers and treatment for abusers. Several comprehensive reviews of the literature have concluded that treatment can effectively reduce both drug abuse and the criminal activities that typically accompany it (Anglin & Hser, 1990; Gerstein, 1990; Office of Technology Assessment, 1990). Many abusers, however, are not necessarily interested in conquering their addictions and will not voluntarily enroll in treatment programs. But a growing body of evidence strongly indicates that abusers who are coerced into treatment programs by the criminal justice system emerge from the programs with the same success rates demonstrated by those who enter treatment voluntarily (Anglin, Brecht, & Maddahian, 1990). Such findings have important implications for policy, both for the criminal justice system (CJS) in its efforts to effectively combat drug abuse, and the drug treatment system. This paper will describe the major treatment approaches and report on evaluations of their effectiveness, especially efforts directed toward substance-abusing offenders, including arrestees, probationers, inmates, and parolees. The attributes of effective programs will be described. Finally, a model for a more effective interaction between the CJS and community-based treatment programs will be proposed.

AN OVERVIEW ON DRUG ABUSE TREATMENT

The four major drug abuse treatment modalities are medical detoxification, outpatient methadone maintenance for narcotics addicts, therapeutic communities, and outpatient drug-free programs. Other modalities and treatment environments exist, but these four account for more than 90% of all clients in treatment as of 1987 (National Association of State Alcohol and Drug Abuse Directors, 1988). Given the historical concern with heroin addicts, two of these treatments (methadone maintenance and detoxification using methadone during withdrawal from opiates) are oriented exclusively toward opiate dependence. Therapeutic community programs have been applied to nonopiate users, even though the approach grew out of the experiences of opiate users seeking a community-based strategy for achieving long-
term abstinence. Only the outpatient drug-free programs were developed without specific reference to opiate users (Brown, 1984).

It should be noted that treatment programs designed for heroin addicts have been most thoroughly assessed over the years, permitting conclusions to be made on the relative effectiveness of treatment modalities and program components. Our current understanding of human behavior and drug dependence is such that many aspects of treatment that are successful with narcotics addicts can be extended to programs for the treatment of cocaine abuse.

**Detoxification**

Detoxification involves the short-term use of licit drugs (such as antidepressants, methadone, or buprenorphine) to manage the client's withdrawal from illicit drugs. Other than providing clients with referrals to further treatment services, detoxification usually offers no subsequent therapeutic or support services. Most detoxification programs focus on narcotics dependence and use methadone to establish a staged withdrawal, typically over 21 days. Detoxification is also used as an initial phase of treatment in therapeutic-community and outpatient drug-free programs. The long-term effectiveness of detoxification has not been demonstrated (Lipton & Maranda, 1982).

**Methadone Maintenance**

Methadone maintenance involves the administration of stable dosage levels of the drug methadone to a drug-dependent individual as an oral substitute for heroin or other morphine-like drugs. Under federal guidelines, clients must have a documented history of addiction and must have received some previous type of treatment. In general, methadone maintenance is intended for patients who have already attempted drug-free forms of treatment and for whom there is little or no expectation that they will be able to function normally without chemotherapeutic support (Dole & Nyswander, 1965). Most methadone programs are in outpatient settings, and include explicit rules for behavior, mandatory counseling sessions, routine urine testing, and medications taken under direct supervision.

Positive outcomes have been obtained in most studies of methadone maintenance, including the Drug Abuse Reporting Program (DARP) (Simpson & Friend, 1988), the Treatment Outcome Prospective Study (TOPS) (Hubbard et al., 1984), and other individual program evaluations. Several recent reviews (Couper et al., 1983; Tims & Ludford, 1984; Senay, 1985) conclude that the research evidence consistently shows significant decreases in both opioid use and criminality, as well as improvements in general health and social functioning for many addicts. Anglin and his colleagues (Anglin & McGlothlin, 1984, 1985; Hser, Anglin, & Chou, 1988), for example, have shown that the percentage of nonincarcerated time during which addicts used narcotics daily decreased from about 70% (averaged across several studies) when not in methadone-maintenance treatment to about 12% when in treatment, and the percentage of nonincarcerated time abstinent from narcotics use increased from about 12% to about 26%. Likewise, property crime involvement decreased from about 18% of nonincarcerated time when not in treatment to about 11% during treatment. Maddux and Desmond (1979) also found that community
crime rates in the San Antonio, Texas area decreased as treatment rates increased, then climbed again when cutbacks in funding caused the premature discharge of patients. In a study of 617 clients in New York City, Philadelphia, and Baltimore, Ball et al. (1987) found that the average number of days per person in which criminal behavior occurred was reduced from 307 in the year before treatment to 18 to 24 days per year after the clients had been in methadone treatment for 6 months or more.

**Therapeutic Communities**

Therapeutic communities are residential facilities in which treatment involves personality rehabilitation and development of positive social relationships within a tightly structured environment. Examples include the early Synanon program and successors like Daytop Village (Biasc, 1981), Phoenix House and Gateway House (DeLeon, 1985). The treatment does not include any chemical agents except when prescribed for medical or psychiatric conditions. The primary treatment approach includes encounter group therapy, tutorial learning sessions, remedial and formal education classes, residential job duties, and, in later stages, conventional occupations for live-in/work-out clients (DeLeon, 1985; Sells, 1974).

This modality involves a highly regimented 24-hour-per-day social setting, with patient involvement in program government and group activities that socialize the individual into accepting more adaptive attitudes and patterns of productive behavior. The optimal residential stay varies among programs, but traditional therapeutic communities require at least 15 months in residence. Some therapeutic communities, however, have incorporated shorter periods of stay, ranging from 6 to 12 months based on clients' needs and progress (DeLeon, 1985). Success is defined as a change to a lifestyle that is drug free, economically productive, and free from antisocial behavior.

Both DARP and TOPS, as well as other reviews of therapeutic communities, have shown significant improvements in immediate and long-term outcomes (DeLeon, 1984). Drug use and criminality declined while measures of prosocial behavior, such as employment and school involvement, increased. The degree of improvement has been directly linked to the amount of time the client spends in the program, but no client characteristics have been identified which predict the likelihood that the client will remain in the program (Anglin & Hser, 1990, and references therein).

**Outpatient Drug-Free Treatment**

Outpatient drug-free treatment includes a wide variety of outpatient nonmethadone programs. When they were begun in the 1970s, such programs were mainly for youthful users of drugs other than opiates. Subsequently, many opiate addicts whose addiction careers were not well established entered outpatient drug-free programs. Whether treating addiction to opiates or the abuse of nonopiates, the same services are typically provided. Treatment regimes usually do not include any chemical agent of medication, but prescription drugs may be used to treat medical problems. Temporary use of psychoactive drugs, such as tranquilizers for psychiatric disorders, is permissible.
The primary treatment approach employs outpatient treatment services, with emphasis on counseling and training in social skills. The components of outpatient drug-free programs vary widely, ranging from structured, daytime, therapeutic-community models to self-help ones that rely almost entirely upon attendance at alcoholics anonymous (AA), narcotics anonymous (NA), and cocaine anonymous (CA) meetings. The planned duration is usually short-term, and referral is made to community agencies for health, mental health, educational, vocational, legal, housing, financial, family, and other required services. This treatment promotes abstinence from both licit and illicit drugs, with attention paid to circumstances that foster drug use.

A nationwide study (TOPS) comparing the three longer-term modalities (excluding detoxification) indicated that outpatient drug-free clients were most likely to leave treatment in the first 1 to 4 weeks (21 and 36%, respectively). By 3 months in treatment, more than 60% had dropped out, transferred, or otherwise stopped treatment (Hubbard et al., 1984). Outpatient drug-free clients have also been reported to be less successful in reducing their drug use and criminal behavior than clients in methadone-maintenance or therapeutic-community programs (Anglin & Hser, 1990).

The preponderance of research findings support the effectiveness of many treatment regimes for drug use (Anglin & Hser, 1990; Gerstein, 1990; Office of Technology Assessment, 1990). A resultant social policy question is how to increase the number of individuals who are treated. Unfortunately, the nature of drug use, especially at abusive and addictive levels, often inhibits or precludes self-motivation in the user toward voluntarily seeking treatment. Identifying users and encouraging or, in the case of drug-abusing offenders, coercing them into treatment is an effort that must be emphasized in order to reduce overall drug demand. When offenders, such as arrestees, probationers, inmates, or parolees, are identified as substance abusers by the criminal justice system, remanding to treatment is a necessary and logical action. Several approaches implementing this idea have been tried during the past 70 years. One of the most successful of coercive efforts has been civil commitment.

CIVIL COMMITMENT FOR SUBSTANCE ABUSE

The civil commitment of substance abusers is a legal procedure—similar to that for the commitment of the mentally-ill—that provides for the involuntary admission of narcotics addicts or other drug abusers to a compulsory drug treatment program typically, but not necessarily, involving an initial residential period of treatment and a community-based aftercare period involving intensive supervision. Provisions are often included during both periods for helping clients with education and employment needs and for responding promptly to signs of relapse—usually detected by regular urinalysis monitoring. Civil commitment has been most commonly used with narcotics addicts who are arrested for criminal activity. With criminal charges pending, the addict can be coerced into treatment and retained long enough to receive the benefits of a treatment program.

This approach is particularly attractive because it results in rehabilitation for the addict while simultaneously reducing demand for drugs during both the residential period and the community aftercare period. These outcomes lead to the socially
desirable goal of reducing the drug dealing and other criminal activities that support illicit drug habits.

Compulsory treatment approaches such as civil commitment have been consistent components of U.S. drug policy throughout most of the twentieth century. Examples include the establishment of morphine maintenance clinics in some communities in the 1920s; establishment of the federal narcotics treatment facilities at Fort Worth and Lexington in the 1930s; experiments with more broadly based civil commitment legislation in California, New York, and at the federal level in the 1960s. The present system, beginning in the 1970s and no longer based on civil commitment legislation per se, relies on community-based drug-treatment programs as an alternative to incarceration or as an adjunct to legal supervision. Histories of compulsory treatment and civil commitment programs are available from several sources (Inciardi, 1988; Maddux, 1986; Musto, 1973).

The constitutionality of civil commitment legislation has frequently been challenged. The U.S. Supreme Court has never ruled directly on the issue, but in a 1962 decision which held that states could not make addiction itself a crime, the Court issued a dictum that civil commitment for drug treatment is constitutional (Rosenthal, 1990). Although a dictum is not necessarily binding on lower courts, most courts do take such dicta into account in reaching decisions. In separate cases, both the California Supreme Court and New York's highest court (the Court of Appeals) relied on this dictum to conclude that civil commitment is, in fact, constitutional. These judicial decisions establish a constitutional basis for current and future implementations of civil commitment procedures for drug dependence.

IMPLEMENTATIONS OF CIVIL COMMITMENT FOR SUBSTANCE ABUSE

Three major civil commitment programs were established in the United States over the past 30 years: the California Civil Addict Program (CAP), the New York Civil Commitment Program (CCP), and programs under the federal Narcotic Rehabilitation Act (NARA) (McGluthlin & Anglin, in press). The latter two, however, were poorly administered and—except for the Federal Bureau of Prisons effort under NARA—inadequately executed, and serve primarily as examples of poor execution of civil commitment programs.

The New York CCP, established by the Narcotics Control Act of 1966, permitted narcotics addicts arrested on relatively minor charges to elect treatment participation for 3–5 years, during which time the criminal charge was held in abeyance. Most eligible addicts, however, preferred the typically shorter prison sentences to the normally longer period of commitment to the treatment program. Furthermore, because the CCP included no provision for mandatory participation in aftercare, few clients completed that phase of the program. Most simply absconded, with little fear of any further criminal penalty. Although aftercare was later made compulsory, it was implemented before state authorities had developed any clear program structure, process, or plan of action. Ultimately, CCP was dismantled without having been evaluated as to its efficacy (Brill & Winick, in press).

The Federal NARA of 1966 was designed to supervise and rehabilitate addicts by providing treatment and aftercare in the clients' home communities. It contained
three treatment-related sections. Title I authorized federal courts to impose civil commitment for any addict charged with certain nonviolent federal offenses. Title II provided for addicts already convicted of a crime (and in the custody of the Federal Bureau of Prisons) to be committed to the custody of the Attorney General for treatment in a Bureau of Prisons facility, followed by parole to outpatient aftercare in addicts' home communities. Title III provided for the civil commitment of addicts not charged with a federal offense (Lindblad & Besteman, in press).

Titles I and III were implemented through the U.S. Public Health System, with addicts to receive treatment for 6 months at the agency's hospitals in Lexington, Kentucky and Fort Worth, Texas. The primary problem with this program was that an unwieldy administrative structure required court approval for each movement of an addict through the system. For every hearing or change of status, an addict had to be transported to and from court using expensive precautions against escape. Furthermore, the need for care was much greater than the capacity of the system, and most addicts referred by the courts were rejected for lack of space (Lindblad & Besteman, in press).

Despite all these problems, Titles I and III did achieve some success (Mandell, in press). Individuals who completed the inpatient phase of treatment did better economically, socially, and in terms of overall health than did those who were not enrolled in the program, and they used drugs less frequently. Severely distressed individuals who were exposed to the program were also more likely to seek help from other programs. Nonetheless, the program was phased out after 1972.

Title II of NARA was implemented more slowly than Titles I and III, and within an established administrative structure, the Federal Bureau of Prisons. As a consequence, it was ultimately more successful. That success was particularly impressive because those treated under Title II were generally the most severely addicted and had the longest criminal histories. On virtually any measure, addicts entering Title II programs tended to "look worse" than those treated under Titles I and III before program entry, but tended to "look better" at the conclusion of treatment. On average, success was more likely for those individuals from better social backgrounds and for those who were most highly motivated to succeed in the program (Kitchener & Teitelbaum, 1990).

Kitchener & Teitelbaum (in press) concluded that such programs could be effective for all inmates with drug-dependence problems if the programs were well designed (i.e., used initial screening, mandatory participation in prison programs, supervised aftercare, intensive parole surveillance, and assistance in obtaining employment) and if clients could be motivated to succeed, either through the sanction of indeterminate sentences or through therapy designed to instill prosocial values. An important finding to emerge from studies of Title II was the effectiveness of the unit management approach, which incorporated the concept of a treatment team. This approach promoted more positive, normal relationships between treatment and custody staff and inmates and resulted in increased institutional security.

**THE CALIFORNIA CIVIL ADDICT PROGRAM (CAP)**

In contrast to New York's CCP and the federal NARA programs, the California CAP—established by legislation in 1961—was generally considered, despite some
flaws, the most effective civil commitment program ever implemented (McGlothlin & Anglin, in press). Its basic premise was that any individual who was found upon medical examination to be addicted to drugs could be remanded into a treatment program. In practice, however, the majority of those remanded had first been arrested for property crimes or drug dealing and subsequently diverted from conventional criminal processing. The 7-year commitment program was divided into two phases: a period of incarceration at a special minimum security facility (the California Rehabilitation Center), and a community aftercare period of intensive parole supervision.

A key element of the CAP was that increasingly severe penalties, including reincarceration, could be rapidly imposed for infractions of program and parole regulations. This level of control provided authorities with a powerful lever to reduce drug use once addicts entered the community release phase of the program. Because parolees were subjected to reasonably effective urinalysis monitoring, any return to compulsive narcotics use could be identified at an early stage or relapse and proper intervention effected (often including a short "dry-out" period of incarceration).

Throughout the 1960s and early 1970s, program results were as good as, or better than, those for other intervention attempts with narcotics addicts (Anglin & Hser, 1990). To some extent, overall outcomes were better because the program could be imposed on an identified addict at any time; thus, the CAP could enroll many antisocial addicts who were not likely to enter conventional treatment programs. Most alternative programs attracted only certain segments of the addict population—namely, those who were less antisocial—and then only in certain periods of their involvement with narcotics, usually later in their addiction careers. That the CAP produced equivalent outcomes with younger, more criminally oriented addicts speaks well of the approach.

Two evaluations of the California CAP illustrate the effectiveness of civil commitment programs. The first study (McGlothlin, Anglin, & Wilson, 1977) compared two groups of addicts—one group was admitted to the program and subsequently released under supervision. The second group of addicts were admitted to the program, but then almost immediately discharged because of legal errors in the commitment procedures. This historical event allowed the second group to act as a natural control against which to assess the effects of the CAP. Table 1 summarizes the effects of the program on multiple outcome measures. In terms of drug use and crime, the comparison shows that during the 7 years after commitment, the program group reduced daily narcotics use by 21.8%, while the discharged (control) group reduced daily use by only 6.8%. Furthermore, individuals in the program group reported that their criminal activities were reduced by 18.6%, while those in the control group reported a reduction of 6.7%. Following discharge from the program, those in the program group continued to show improvement on some measures.

A second evaluation (Anglin & McGlothlin, 1985) focused on the program group. The group was divided into three subsamples according to their narcotics use and treatment status in the 3 years prior to the interview, approximately 9 years after admission to the program: (1) a maturing-out sample (Winick, 1962); (2) a subsequent-treatment (methadone maintenance) sample; and (3) a chronic addict sample.

Figure 1 demonstrates the addiction career history of these three groups for four critical periods: (1) the period before commitment to the CAP; (2) the stipulated commitment period (averaging about 5 years); (3) an early postdischarge period; and (4) a later postdischarge period during which the subsequent-treatment group
Table 1. Summary of mean precommitment and postcommitment status and behavior for comparison (C) and treatment (T) samples

<table>
<thead>
<tr>
<th>Status or behavior</th>
<th>Comparison</th>
<th>Treatment</th>
<th>Mean differences between change scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td>Mean arrests per year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug arrests</td>
<td>1.06</td>
<td>0.95</td>
<td>0.67</td>
</tr>
<tr>
<td>Nondrug arrests</td>
<td>1.13</td>
<td>1.18</td>
<td>0.90</td>
</tr>
<tr>
<td>Parole violations</td>
<td>0.10</td>
<td>0.31</td>
<td>0.32</td>
</tr>
<tr>
<td>Mean % of time incarcerated</td>
<td>23.2</td>
<td>50.9</td>
<td>31.7</td>
</tr>
<tr>
<td>Mean % of nonincarcerated time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under legal supervision</td>
<td>31.7</td>
<td>52.6</td>
<td>60.0</td>
</tr>
<tr>
<td>Using narcotics daily</td>
<td>54.5</td>
<td>47.7</td>
<td>28.4</td>
</tr>
<tr>
<td>Dealing drugs (with or without profit)</td>
<td>46.9</td>
<td>38.2</td>
<td>25.1</td>
</tr>
<tr>
<td>Employed (full or part time)</td>
<td>44.8</td>
<td>48.8</td>
<td>53.0</td>
</tr>
<tr>
<td>Alcohol abuse*</td>
<td>30.0</td>
<td>36.8</td>
<td>37.4</td>
</tr>
<tr>
<td>Mean no. self-reported crimes/year</td>
<td>66.0</td>
<td>77.0</td>
<td>52.0</td>
</tr>
<tr>
<td>Mean income ($000) from crime/year</td>
<td>45.0</td>
<td>72.0</td>
<td>48.0</td>
</tr>
<tr>
<td>Composite score: % of time alive, not incarcerated, and not using narcotics daily</td>
<td>35.3</td>
<td>27.9</td>
<td>45.9</td>
</tr>
</tbody>
</table>

Period I = First narcotic use (N1) to civil commitment (A).
Period II = A to (A + 7 years) the legislated period of commitment.
Period III = (A + 7 years) to time of interview (I).

*The percentages in this table are the mean of individual percentages for the respective periods, not the percentage of the overall person-months.
1*Data on arrests, self-reported crimes, and income from crime are rates per nonincarcerated person-year. Crime income does not include drug dealing, gambling, etc.
2Alcohol abuse is defined as drinking at least a six-pack of beer, or a bottle of wine, or seven drinks of liquor over a six-hour period two or more times per week.
3Significant beyond the 0.05 level of confidence.
4Significant beyond the 0.01 level of confidence.
5Source: An Evaluation of the California Civil Addict Program, NIDA, 1977.
entered methadone maintenance (MM). The entry to MM is indicated by the letter M.

Prior to CAP commitment, the three groups were relatively similar in terms of their levels of daily narcotics use. Admission to the CAP, however, caused a differential change in the level of daily use. The maturing-out sample, approximately 40% of the program group, steadily reduced daily narcotics consumption during the commitment period and did not resume addiction-level use after discharge from commitment. At the time of the interview, however, many in this group used narcotics occasionally.

The subsequent-treatment sample, approximately 30% of the program group, showed a large decrease (about 25%) in daily drug use during the commitment period. After discharge, however, use by this group resumed its precommitment level until the group re-entered long-term treatment, this time with methadone maintenance. Entry into this treatment modality had an immediate and significant effect on levels of use.

The chronic addict sample, also approximately 30% of the program group, showed a moderate reduction (about 10%) in daily narcotics use during the commitment period. After discharge, however, use rose to a level exceeding that reported in the precommitment period and was still high in the year preceding the interview: for that year, the chronic addicts described themselves as addicted 55% of their non-
incarcerated time. Figure 2 shows a similar temporal pattern for levels of property crime activity among the three groups.

These studies have at least two important findings that may be regarded as measures of the effectiveness of civil commitment as implemented in the California CAP. First, daily narcotics use and associated property crime by program participants were reduced to a third as much as was achieved with similar addicts who were not in the program. Second, while the program’s effects differed across three types of addicts, narcotics use and crime were suppressed to some degree in all three groups. Unfortunately, these results were not available to California corrections planners in a timely fashion, and the CAP, although still utilized, decreased in size and programming effort in the late 1970s.

THE TASC PROGRAM

Given an increasing network of community-based treatment programs in the late 1960s and early 1970s, many jurisdictions developed co-ordinated programs to refer drug-abusing probationers to community-based treatment programs in lieu of prosecution or probation revocation. One such program, called Treatment Alternatives to Street Crime (TASC), was initiated in 1972 and by 1988 was in operation in
18 states (Cook et al., 1988). TASC was a natural outgrowth of NARA, and funding provided under Title IV of NARA helped to develop many community programs used by TASC. TASC provides alternative treatment for drug-dependent individuals who otherwise might become progressively more involved with the criminal justice system. To motivate drug-abusing offenders to enter and remain in treatment, TASC employs diversionary dispositions, such as deferred prosecution, creative community sentencing, and pre-trial intervention. Dropping out of treatment or other noncompliance is treated by the courts as a violation of the conditions of release.

Evaluations of the impact of TASC have been limited (Anglin & Hser, 1990). Most TASC programs, however, are believed to have performed the treatment-outreach function successfully. Sells (1983), for example, reports that 50% of the referrals were entering treatment for the first time. Although no detailed supportive data are available, some independent local evaluations have concluded that local TASC programs effectively intervened with clients to reduce drug abuse and criminal activity (Cook et al., 1988). No solid data base or data collection mechanism is in place for long-term evaluations of TASC and its effects on drug-related crime or on activities of the criminal justice system.

The only available evaluation of the impact of TASC or similar programs is based on the Treatment Outcome Prospective Study (TOPS) (Collins & Allison, 1983; Hubbard et al., 1988). TOPS compared clients remanded by the criminal justice system (in TASC and under other forms of CJS supervision) to voluntary drug-treatment clients in terms of demographic characteristics, treatment retention, treatment progress, and predatory behavior in the year following treatment termination. TASC clients improved as much as voluntary clients with respect to drug use, employment, and criminal behavior during the first 6 months of treatment. TASC clients also tended to remain in both residential and outpatient drug-free modalities 6–7 weeks longer than did voluntary clients or those under other criminal justice system referrals—a finding usually associated with better treatment outcomes (Anglin & Hser, 1990). The monitoring functions of TASC seem to have encouraged this longer treatment participation.

**CJS UTILIZATION OF COMMUNITY-BASED TREATMENT**

Several studies have shown that less formal application of legal pressure increases admission rates into treatment programs by substance-abusing offenders and may thereby promote better retention in treatment, consequently improving the overall results of the program. McFarlain et al. (1977), for example, found that legal pressure increased retention in therapeutic communities. Similarly Schnoll et al. (1980) found that in an inpatient treatment program clients admitted immediately after release from prison were more likely to complete the program.

Longitudinal data from the DARP studies also indicated that coercion did not impair the effectiveness of community-based treatment programs. Sells and associates (1976a, 1976b, 1976c) and Simpson and Friend (1987) examined the relationship between contact with the criminal justice system at admission and length of stay in treatment, as well as client performance during and after treatment. These studies found that those entering treatment with some legal involvement performed
as well as those who entered voluntarily. The studies also showed, however, that while legal status may have been a major reason for treatment entry, it did not significantly contribute to long-term retention, as indicated by discriminate functions estimated separately for methadone maintenance, outpatient drug-free programs, and short-term therapeutic-community programs.

Similarly, Anglin, Brecht, and Maddahian (1990) compared three groups of male heroin addicts, totaling 296 individuals, who entered methadone maintenance under high, moderate, or low threat of legal coercion. They found no significant difference among the groups in the improvement levels of drug use and criminal behavior. These groups could not be distinguished in terms of their behaviors, indicating that those coerced into treatment benefited just as much as those entering voluntarily.

Brecht and Anglin later (1990) replicated their study on a larger, more diverse sample of methadone-maintenance admissions and found similar results for men and women and for white and Mexican-American heroin addicts.

More recently, Anglin and Powers (1990) studied 202 methadone-maintenance clients who had experienced each of four different intervention conditions during their addiction careers: (1) methadone maintenance alone, (2) intensive legal supervision alone (parole or probation with urine testing), (3) both interventions simultaneously, and (4) neither type of intervention. Overall, intensive legal supervision was better than no intervention in improving the drug-related behavior of narcotics addicts, and methadone maintenance was better than legal supervision. The combination of methadone maintenance and legal supervision generally produced no improved behavior over methadone maintenance alone, except with regard to improved abstinence rates, an important treatment outcome measure. The study also showed no differences in the effectiveness of the therapies with respect to gender or ethnicity, suggesting that the combination of legal supervision and methadone maintenance—or other treatment modalities—should be effective for any group.

The preponderance of empirical evidence indicates that treatment for drug abuse is effective and that its effectiveness is not diminished when addicts are coerced into treatment by the criminal justice system rather than entering into treatment voluntarily. But the results obtained from many different program evaluations indicate that outcomes can vary widely, depending on how programs have been implemented. Treatment programs established for substance-abusing offenders must be developed with regard to which components of previous programs have been shown to make them most effective.

**Attributes of Effective Treatment Programs**

Several program components and characteristics, when appropriately implemented, have been identified as being effective in treating CJS-remanded drug abusers (Anglin & Hser, 1990). Important program characteristics include treatment philosophy, program policies, qualifications of staff, and other quality-of-care aspects. Notable components include psychotherapy, urine testing, legal coercion and CJS monitoring, and efforts to promote greater retention. A recent study by Joe, Simpson, and Sells (in press) of 590 methadone-maintenance clients from the TOPS evaluation
also suggested that—for this modality—a higher methadone dosage level, more frequent urine testing, and more frequent dosage take-home privileges were correlated with longer treatment retention and lower relapse rates.

Most studies of psychotherapy for drug abusers have been performed with methadone-treated narcotics addicts. In eight studies reviewed by O'Brian et al. (1984), opiate-dependent patients were randomly assigned to psychotherapy or to a treatment control condition, usually drug counseling. Six of the studies (75%) showed a better outcome for clients in psychotherapy than for those in the control group.

A similar study in New Haven, however, did not find a significant effect for psychotherapy (Rounsaville et al., 1983). The study evaluated short-term interpersonal psychotherapy—a brief psychodynamic therapy—for 72 methadone-maintenance clients diagnosed as having concurrent psychiatric disorders, such as anxiety or depression. The multiple outcome measures included treatment attrition, number of urine positives for illegal drugs, number of arrests, number of psychiatric symptoms, personal and social functioning, and attainment of individual goals. Attrition was high in both the treated and control groups, and the evaluation showed few differences between the two groups.

The contrast between the outcomes of the two studies indicates that the recruiting and implementation strategies suggested by Woody et al. (1983) should be included in the design of additional treatment trials. These strategies include the integration of a broad range of clients early in treatment and the integration of drug-treatment and psychotherapy staff.

Monitoring of illicit drug use by urine testing has been a common practice in most drug-treatment programs and in the CJS-supervised programs for parolees and arrestees with drug-use histories (Wish & Gropper, 1990). Considerable evidence points to its effectiveness when linked to sanctions applied to those who test positive. McGlothlin et al. (1977) found that urine testing in criminal justice system settings, and in combination with intensive legal or other supervision and with sanctions for detected drug use, was more effective than supervision without testing in reducing daily narcotics use and criminal activity by the narcotics users admitted to the California CAP. Similar results were obtained in later work with methadone-maintenance clients (Anglin, Deschenes, & Speckart, 1987; Speckart, Anglin, & Deschenes, 1989), in which it was found that the combination of legal supervision and urine testing significantly suppressed both narcotics use and concurrent property crime, although the latter behavior responded less dramatically.

Retention in a treatment program and the type of discharge are program characteristics that have been consistently related to client status at follow-up. These characteristics are valuable measures of a program's ability to maintain client contact and enhance prospects for a therapeutic relationship that facilitates positive treatment outcomes. With few exceptions, most studies on the length of treatment find that longer treatment retention is associated with reduced drug use and crime and increased employment (McGlothlin & Anglin, 1979; Simpson, 1979, 1981). Simpson's study of DARP data (1981) also suggests that a minimum duration in treatment is necessary for effective treatment. Treatments lasting less than 90 days appear to be of limited benefit, regardless of the type of treatment involved. Beyond 90 days, however, treatment outcomes improve in direct relationship to the length of time spent in treatment (Anglin & Hser, 1990). These findings are consistent with results from studies of therapeutic community programs in the community by
DeLeon et al. (1979), DeLeon & Schwartz (1984), therapeutic community programs in correctional settings (Wexler, Lipton, & Foster, 1985), and methadone maintenance programs (Ball et al., 1987).

Interpretations of these results are complicated, however, by the likely selective termination of patients with poorer prognoses (Maddux & Bowden, 1972). Baekland and Lundwall (1975), for example, in their critical review of the literature, concluded that "remainders" are likely to be a more stable group initially, and this may make better treatment outcomes more likely. Remainders tend to have higher rates of pretreatment employment and fewer total arrests and tend to be slightly older than dropouts. Furthermore, follow-up studies often show some degree of improvement in minimal treatment or untreated groups as a function of the passage of time (Burt Associates, 1977).

Since programs can exert influence only when patients are enrolled, retention has been viewed as an important goal of all treatments and a variety of studies have attended to factors related to retention. A common finding is that those who exhibit greater psychological disturbance, particularly depression, are more likely to leave treatment prematurely (Wexler & DeLeon, 1977; Steer, 1980; Woody et al., 1981; McLellan et al., in press). Several demographic variables have been found—but not always consistently—to be predictors of retention. In general, clients who are black, unmarried, unemployed, polydrug abusers, or who have longer conviction records are more likely to drop out of treatment (Steer, 1980). Sansone (1980) found lower retention rates for women, Hispanics, and other non-black minorities. DeLeon (1987), however, claimed that correlates between clients' demographic characteristics and retention have been weak, while motivation, perception, and the client's readiness for treatment appear to be more relevant to retention. Collins and Allison (1983) reported that drug abusers who are legally coerced into treatment stay longer. McFarland et al. (1977) found that retention was positively related to legal pressure, but only in the initial phases of treatment. They also reported finding no relationship between retention and either age or race.

Other research suggests that an expanded definition of retention may be needed. Simpson et al. (1978) report that 39% of methadone-maintenance clients and about 25% of outpatient drug-free clients returned to treatment within a year. Sansone (1980) found slightly higher retention for clients on re-admission, regardless of age, sex, or racial background. These findings raise the possibility that, for many drug abusers, repeated exposure to treatment is more effective than one episode (McLellan & Draley, 1977). In this respect, the total time in treatment may sometimes be more important, when accrued across multiple treatment episodes, than retention in a single program.

The program policies and staffing of drug treatment providers are more diverse than the program modalities, components, and approaches that are applied by those providers. Of all the aspects of treatment structure, program policy and its execution by staff are perhaps the least quantifiable (and least studied) in terms of their effects on treatment outcomes (Sells & Simpson, 1976). Nevertheless, clinical impressions by many observers concur that disparate outcomes are often a function of program policies and the manner in which staff implement those policies. Different outcomes are noted even when comparing programs that are virtually identical in their components and structures (Ball et al., 1986).

Limited evaluation data describe the influence of program policies and staff imple-
mentation. In a study of three methadone-maintenance programs in Southern California (McGlothlin & Anglin, 1981a; Fisher & Anglin, 1987), two programs with similar dosage levels and with flexible policies with respect to client management, discharge for program infractions, and degree of supportive counseling had better retention times—a primary indicator of treatment-effectiveness—than did a third, less flexible program. Of the two flexible programs, the one with the more adaptive policy on client infractions retained 77% of admissions for 2 years, while the program with a more punitive orientation retained only 42%. The third program, with the least flexible policies (and a mean dosage level about one-half that of the other two), retained only about 25% of admissions after 2 years. These differences could not be explained by pretreatment differences among the three programs in the race or age of the male samples studied.

Outcomes within therapeutic communities also vary considerably. DeLeon (1985) reported 3-month and 6-month retention rates for seven therapeutic-community programs in which the highest rates were 46% and 35% and the lowest were 23% and 18%. Reasons reported by those leaving treatment prematurely included program factors such as conflicts with staff and differing views of treatment. DeLeon concluded that improved outcomes were influenced by relations between the overall treatment environment and specific treatment elements.

The connection between staff characteristics and treatment efficacy was also noted by Joe et al. (in press). Positive outcomes were associated with higher professional quality of the staff involved in diagnosing clients at admission and in designing treatment plans. Similar findings were obtained by Ball et al. (1986) in his study of six methadone-maintenance programs in three East Coast cities. Wide variations in outcome were observed in programs of similar design. Results were partially attributable to intangible factors of program “personality” that were affected by staff attitudes and approaches. Ball’s study included confidential interviews with program personnel, from which emerged a relationship between program morale and treatment effectiveness.

Results of these few studies on program policies and staffing suggest that evaluation of this aspect of treatment must be more carefully considered when determining appropriate treatment designs.

POLICY IMPLICATIONS: A MODEL TREATMENT SYSTEM

The necessity of treatment for drug-dependent groups suggests the desirability of expansion of treatment services and legally coerced treatments for drug users identified by the criminal justice system (Gerstein & Harwood, 1990). Expanded treatment capacities will produce benefits to society and allow clients who need or desire treatment to benefit more readily from such services. Treatment outcome studies also suggest that a complementary system of other rehabilitation services will achieve additional beneficial treatment effects.

We must pay close attention to the design and implementation of new and continuing treatment programs mandated by the criminal justice system. Four main issues need to be considered. First, the period of intervention must be lengthy because drug dependence (especially dependence on heroin and cocaine) is a highly relapse-
prone condition. Except in a minority of cases, several cycles of treatment (possibly including different modalities), aftercare, and relapse must be expected, and it is not unreasonable to assume that long-term, carefully planned intervention will be necessary to control, reduce, or eliminate drug dependence in any given individual.

Second, programs must initially provide a high degree of structure—such as a residential stay in a controlled setting or very close monitoring in an outpatient setting—so that the user can be detoxified from illicit drugs and thoroughly assessed, after which an individual program plan can be instituted. The initial period of close control should be followed by a carefully structured program of further treatment and subsequent aftercare. Objective monitoring for drug use by urine testing will often enhance outcomes by diminishing the likelihood of relapse. Even in programs with strong supportive services, where such monitoring may not obtain direct effects, drug testing can still provide clinically useful information for treatment staff (Joe, Simpson, & Hubbard, in press). Other ancillary interventions that encourage retention in treatment and in community aftercare and that prevent relapse should be provided on an individual basis; these include psychiatric care, psychological services, and job training.

Third, programs must be flexible; no absolute mandates should determine individual treatment structure. Some level of continued or substitute drug use may be expected from the majority of those in community-based programs, whether or not clients are under criminal justice system auspices (McGlothlin et al., 1977; Anglin & McGlothlin, 1985). Intermittent drug use that does not seriously disrupt the individual's program plan should be dealt with on an individual basis in the context of the client's overall adjustment. Any detected relapse, however, requires immediate program reactions such as, in the case of heroin use, placement in a residential setting for detoxification or in a methadone-maintenance or naltrexone-blocking program.

Finally, any intervention program must undergo regular evaluation to determine its level of effectiveness and whether changing characteristics of clients require compensatory changes in the program. Program staff and policies must be kept current with developments in the drug treatment field so that suitable new methods can be adopted and staff adequately trained in their use.

Treatment components that seem especially important to incorporate in treatment programs for drug-abusing offenders include intake assessment and provision of indicated medical treatment and psychotherapy; attention to polydrug-use problems such as alcoholism or secondary illicit drug use (D'Amanda, 1983) to ensure early detection and early intervention; and increased provision of ancillary services (Ball et al., 1987; Wermuth, Brummett, & Sorenson, 1987). Providing job training and employment opportunities are important so that clients in treatment do not need to remain enmeshed in the drug-abuse subculture of drug dealing, property crime, and related activities to meet their economic needs. This is especially important for disadvantaged groups, particularly for women with responsibility for child rearing.

Although the above suggestions are amply supported by research findings and have been known within the field for a long time (Sells, 1974), their implementation has been difficult. Treatment programs exist in the context of competition for resources with other social programs, a lack of adequately trained staff, and, perhaps most important, a history of shifting and unstable funding.

By the mid-1980s, societal concerns with cocaine- and crack-related crime and
HIV infection in intravenous drug users began to promote greater public and policy attention. Increased enforcement activities and stiffer penalties for drug possession and sales drove prison and jail overcrowding to unprecedented highs. Concomitantly, enforcement and corrections costs began taking a larger and larger share of tax dollars, so less costly alternatives have been sought. Diverting drug-abusing offenders from incarceration into treatment has potential return for reductions in community crime, improved health, and lowered correction costs. Recognition of these benefits has led to increased federal and state funds being allocated to improving the availability and quality of drug abuse treatment. Many obstacles to enhancing the treatment system exist, however, and increased funding will not necessarily overcome them: few outreach efforts exist to induce drug users to come into treatment voluntarily; qualified and willing staff are in short supply; and neighborhoods are resistant to the placement of treatment programs because of mistrust and suspicion toward clients.

What is needed, in addition to adequate funding, is a cogent strategy to upgrade our present treatment system at all levels, with concentrated efforts to implement those treatment elements acknowledged to be effective. A more rapid incorporation of new elements emerging from ongoing research into the established treatment protocols is also needed.

A treatment system with a more integrated interconnection with the CJS would increase the percentage of users who will reduce or cease their use of drugs in each year after intervention. Combating the chronic relapsing nature of drug dependence requires consistent and persistent long-term efforts. These efforts must be applied within a system of flexible treatment structures that are appropriate to individual client characteristics. Treatment approaches that operate on these precepts have the potential to effect a lasting amelioration of many of the problems of drug abuse.

Figure 3 presents a simplified model for an integrated dynamic system of social intervention in drug abuse. The figure delineates three aspects of the model: first, the levels of addiction, moving from the global perspective of the population in general to a level addressing the most recalcitrant drug-abusing offender; second, the reasonable intervention strategies to apply at each level; and third, the movement of drug-using individuals through the various phases of addiction and the points at which intervention strategies can be applied.

Drug users are not restricted to a particular socioeconomic group or ethnicity or sex—they come from all segments of the general population. Most individuals do not become involved with illicit drugs or do so in a very limited way. Of those who ever use an illicit drug, only a small proportion escalate their use to a casual or even to a regular level for some period of time. From this latter group, certain individuals escalate into habitual, dependent, or addicted use. The proportion of users who become habituated varies depending on the particular drug they use and on many subjective, personal factors.

Improved outreach efforts targeting many segments of the population are necessary to increase the number of drug users in treatment. The first problem for a rational intervention approach is to detect those who are using drugs. Detection typically occurs through social agencies or self-disclosure. Social agencies that typically detect users include hospital emergency rooms, law enforcement agencies, and third parties such as employers, parents, or school officials who have reason to suspect drug use. Self-disclosure occurs when drug use becomes a sufficiently severe problem.
Intervention Stages

General Population

Available for Assessment

Assessment

Suitable for Intervention

Non-incarcerated CJS Control Levels

Drug Testing

CJS Monitoring

Civil Commitment

Assessment of Behavioral Violation

Incarceration

Release

No illicit drug use

Occasional use

Heavy use

Involved in Drug Sales

Social Detection

Personal Disclosure

Voluntary

Coerced

Low

Medium

High

Education

Early Intervention

Treatment

Outpatient

Drug Use

Residential

Methadone

Residential

Methadone

Blockers

Violation of Conditions

New Offenses

Relapse to use

Short-term

Long-term

Social Intolerance of Use

Proven Prevention Interventions

- Community-based
- School-based
- Family-based
- Mental Health Services

Detection

- Drug testing
  - Arrestees, ER clients
  - Probationers, Parolees
  - Clinic clients, Military personnel, Employees
  - Students
  - Case-History/Self-report
  - Third party notifications

Disclosure

- Treatment on demand
- Outreach efforts

Community Programs

- Remedial Education
- Vocational training
- Mental Health Services

Institution Treatment Programs

- Remedial Education
- Vocational training
- Mental Health Services

Figure 3. Dynamic system of intervention integration user flow.
for an individual that he or she discloses the problem to a third party or seeks treatment. However, identifying drug users who come into contact with the criminal justice system will be crucial in intervening and admitting to treatment a large segment of the drug-using population.

Individualized assessment procedures should be designed to determine an appropriate level of intervention for identified drug users. Of course, those detected by external means may not be motivated to change (e.g., arrestees and adolescents deeply involved in drug-use subcultures). For these individuals, some level of coercive intervention or control will be necessary to produce any desired changes in behavior.

Once a drug user has been identified, careful assessment must be made of the user’s drug history, current level of use, and problems associated with drug use. Such assessment should be designed to: (1) allow a choice of intervention strategies, including both community treatment and criminal justice alternatives; and (2) provide enough flexibility and sufficient ancillary services to achieve success in both short-term and long-term behavioral change.

The intervention efforts proposed in the integrated dynamic system depicted in Figure 3 involve various levels of community-based treatment. On the criminal justice side, the lowest levels of intervention may involve diversion of individuals from court processing into drug education or treatment programs or the imposition of treatment as a condition of probation. At higher levels, treatment may be imposed as a condition of early release from incarceration, as an adjunct to parole after incarceration, or as a condition of remaining unincarcerated for violations of parole or early release conditions. For community-treatment efforts, interventions may include simple educational approaches or outpatient counseling, methadone maintenance and other pharmacotherapies, residential treatment, and self-help programs such as Narcotics Anonymous. The integration of these two dimensions of intervention may provide nearly any level of monitored control and intensity of treatment that may be desirable for a given individual.

One fact-based axiom of this model merits further emphasis. Drug dependence is a chronic condition requiring protracted intervention for resolution. This axiom is particularly applicable to the treatment of narcotics addiction, where 10- to 30-year histories of abuse are not uncommon. The treatment outcome studies on which this model is partially based indicate that long-term investment in rehabilitation is necessary in many cases. Thus, some proportion of drug users will need years of treatment or even permanent case management. In addition, for many drug-using individuals, recovery may be interrupted by personal or social circumstances that produce relapse.

The model proposed here is designed to anticipate and intervene as early as possible in the relapse cycle. Under real world conditions, it is evident that monitoring the behavior of clients is necessary for two reasons: first, to promote and sustain the recovery process initiated during successful treatment and, second, to identify potential relapse conditions so that additional intervention can be devised and applied early in the cycle, before prior gains are eroded or lost. The lines and arrows in Figure 3 that connect the various stages in the model depict the monitoring and dynamic intervention flow as it applies to individuals moving through the system.

While it is always hoped that any given intervention will produce positive results, the model allows for flexible and integrated responses. If the original intervention strategy is not producing desired results, a higher level of control with greater treat-
ment intensity may be applied. At the lower levels of drug involvement, for example, simple diversion with criminal justice monitoring (including drug testing and/or community-based treatment intervention involving education or outpatient counseling) may be imposed for a predetermined period of time. If individuals can then demonstrate that personal control has been achieved for a sufficiently long period, then these constraints can be removed. At the other extreme (i.e., for the chronically relapsing CJS client), intense legal supervision after a period of incarceration or inpatient may be necessary, followed by high-intensity community-based treatment such as methadone maintenance or residential care. The recalcitrant individual will also need careful monitoring for a longer prescribed period, during which he or she must demonstrate sufficient control before constraints are removed.

In a number of respects, the model proposed here is similar to that used to manage the chronic mentally ill. Reasonable goals for the model as applied to drug users remanded by the criminal justice system are to minimize the numbers entering more restrictive stages, to minimize the use of more serious and costly options of long-term incarceration or residential treatment, and to maximize time in the community while behavior is maintained at an acceptable level. For many CJS referrals, this process may be accomplished within a few years. For others, long-term intervention or lifetime case management may be necessary.

Research on drug abuse treatment demonstrates significant declines in drug use and criminal behavior by drug-dependent clients as a result of treatment (Cooper et al., 1983; Tims & Ludford, 1984), although we lack adequate data to enable optimal matching of specific types of treatments to individual drug abusers. Furthermore, a growing body of evidence indicates that such treatment is just as effective for substance abusers coerced into treatment by the criminal justice system as it is for clients who enter it voluntarily, substantiating the move to greatly increase the number of drug-dependent arrestees, parolees, and inmates who are enrolled in treatment programs. This is not only rehabilitative for the CJS-diverted substance abusers but also beneficial to society because it will reduce drug use, crime, and the overcrowding of prisons.

**CONCLUSION**

All elements necessary for developing the proposed integrated treatment system are available and in accord with current social policies. The criminal justice system has relied on community-based treatment ever since it became widely available. Community-based drug treatment has matured from a sparse scattering of programs developed in the late 1960s and early 1970s to a well-established nationwide network.

Despite these advances, two major problems will have to be resolved before the system is both efficient and effective. The first and most serious of these problems is the erratic level of funding for treatment programs. At present, there are long waiting lists for spaces in community-based treatment programs. The situation is being remedied partly by increased funding and partly by providing other resources to complement the current delivery system. These other resources include higher salaries for practitioners, better continuing education programs, and greater access to such ancillary resources as educational and vocational training. These increases in funding and training, however, must be sufficient and must be part of a long-term
commitment to maintaining an effective treatment system for drug abuse.

Second, no widespread outreach efforts are currently in place to induce drug users to seek treatment voluntarily. Such efforts could certainly increase the total number of users in treatment, and at a smaller implementation cost (especially in terms of criminal justice system expenses) than that required for legal coercion or civil commitment.

Without these two changes, expansion of legal coercion or civil commitment programs would be appropriate only for those substance abusers who are unlikely to enter treatment voluntarily and whose behavior is sufficiently problematic to warrant criminal justice system intervention.

Problems in the criminal justice system also need to be addressed. Many members of this system are not knowledgeable about the benefits of community-based treatment. A substantial number mistakenly believe that such treatment is ineffectual or coddles the drug user, and they may consequently hinder the implementation of programs. In addition, communication and co-ordination between the criminal justice system and the treatment system must be improved. Members of both systems need to move away from adversarial stances and toward collaboration to produce the desired behavioral changes in drug users.

REFERENCES


Coerced treatment


