Section 5: Special features

- People with mental illness in the criminal justice system
- Project Safe Neighborhood (PSN)
- Terrorism at home: Firearms and domestic violence
- At least half of those arrested in Denver need drug treatment
- What works for drug and alcohol treatment?
- Economic costs of drug abuse in the United States

People with mental illness in the criminal justice system

The need for Crisis Intervention Teams (CIT) in Colorado

The entire nation is grappling with the escalating problem of people's inability to access needed mental health services.

Public funding allocations for mental health resources has been steadily decreasing and is insufficient for those with mental illness in need of services. According to a study by the Colorado Division of Mental Health Services and the Western Interstate Commission for Higher Education (2002), over 66,000 Coloradoans with serious mental illness were unable to access treatment services in 2002. At the same time, in 2002 and 2003, the budget for Colorado's public mental health system decreased by over $10 million.

Consequently, our nation, and particularly Colorado, where public funding for health care continues to shrink, has ended up serving many of these individuals through their involvement in the criminal justice system. The number of persons with serious mental illness in correctional and detention facilities nationwide has been escalating for a number of years. Currently in Colorado, over 24 percent of juveniles in the Division of Youth Corrections have a serious emotional disorder and 16 percent of adults in the Department of Corrections have been diagnosed with a serious mental illness. Many of these persons also suffer from substance abuse problems.

A man was creating a ruckus at a grocery store. CIT officers arrived and were able to find out that the subject had received mental health treatment in the past and was currently on medication. He had delusions that his father had killed someone and he stated that he had to murder his father in order to stop the cover up. Because there was a warrant out for him in an adjoining county, officers transported him to that jail, but in the meantime made contact with the father to make sure he was OK. The father was then able to provide the officers important information pertaining to his psychiatric condition, which the officers were able to transfer to officials at the jail.

Officers stated that prior to CIT, they would not have understood the need to invest the time required to de-escalate the man or gather all the information they did.

But these institutions are poorly equipped to handle this population, and confinement can seriously aggravate the symptoms of many mental illnesses.

"In academy I learned to interrogate. In CIT, I learned to communicate."

– Police Sergeant
Wheat Ridge, Colorado

Recognizing this as an important problem facing the state, in 1999, the Colorado General Assembly created the Legislative Interim Committee on the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System. The Committee designated a Task Force for the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System (MICJS), comprised of experts representing the spectrum of statewide mental health and criminal justice agencies, to identify solutions and recommend legislation to address the rising problem.

One initiative recommended by the Task Force and pursued by the Interim Committee was a jail diversion strategy called Crisis Intervention Teams (CIT). This approach was developed in 1988 by the Memphis Police Department in response to a deadly police shooting.

The Crisis Intervention Team initiative is built upon community partnerships designed to train law enforcement, address mental health service gaps, and develop system responses for those with mental illness and other disabilities. It begins with a 40-hour training experience that provides law enforcement officers new strategies and tools for identifying and de-escalating mental health crisis situations – calls that sometimes involve interactions that threaten both officer and civilian safety.

A key goal of CIT is helping officers recognize that untreated mental illness can sometimes lead to behavioral problems that come to the attention of law enforcement. Officers exercise discretion in determining the disposition appropriate to each individual's situation or referring them to services suited to their presenting needs. Employing this strategy reduces arrest and further penetration into the criminal justice system for many encountered citizens.

CIT training is provided by experts in the community who donate hundreds of workshop by hours sharing their knowledge with police officers. Professional actors role-play with officers learning de-escalation strategies. The training is organized by the Colorado

Regional Community Policing Institute in the Division of Criminal Justice. Byrne Memorial Grant funding has provided the financial support for both the implementation and evaluation components of the project. What began as a one county, six agency pilot program in May 2002, has now spread to 40[26] agencies in twelve counties, with over 1,000 Colorado law enforcement officers having received CIT training.

CIT diverts over 1500 from arrest and confinement

CIT training has been enthusiastically received throughout the participating law enforcement communities. Its success is rooted in the relevancy of the training to public safety and the impact officers are having on the street.

Table 5.1. Disposition of CIT law enforcement* contacts May 2002-April 2005 (n=1611)

Disposition	Percent
Hospital	76%
No placement needed	16%
Arrested	3%
Mental health center	1%
Detox	1%
Other**	3%

Notes: *See footnote on this page for participating agencies. **An additional 3 percent were resolved in a variety of ways, including residential placements (youth and elderly) family members, other services, etc.

Source: Evaluation data obtained from law enforcement officers and analyzed by the Office of Research and Statistics, Division of Criminal Justice.

A comment published by an Aurora citizen in the Rocky Mountain News on 8/23/04: "[A man] died at home after a long struggle with AIDS. We were wrecked...the police arrived [and] we met officer Todd Allum. What can I say about the man? He showed compassion, he said the most beautiful things, he gave comfort in a time of crisis and sorrow. Denver should be proud to have this man on its force." Todd Allum is a CIT officer.

"When I first heard about CIT, I was skeptical. I've been in law enforcement a long time and couldn't help but wonder: 'Is this the flavor of the month? Just another policing and PR program?'…And here we are, one year after our first class. We have seen success so quickly. CIT has proven itself and I know that in the future, CIT is what successful officers will use in the field to really have a positive impact on the streets – in their work as peace officers."
– Police Commander, Wheat Ridge, Colorado

Table 5.2. CIT law enforcement* contact demographics May 2002-April 2005

Contact demographics	Percent
Gender (n=1630)	
Male	53%
Female	47%
Age (n=1595)	
0-17	21%
18-35	37%
36-60	37%
61+	5%
Ethnicity (n=1541)	
Caucasian	79%
African American	9%
Hispanic	10%
Other	2%

Note: *See footnote on this page for participating agencies.

Source: Evaluation data obtained from law enforcement officers and analyzed by the Office of Research and Statistics, Division of Criminal Justice.

Table 5.3. Mental illnesses most commonly reported to CIT officers May 2002-April 2005 (n=1021)

Reported mental illness	Percent
Depression	34%
Bipolar	33%
Schizophrenia	14%
Other*	19%

Note: *Other included a variety of illnesses such as Post Traumatic Stress, Attention Deficit, and Anxiety Disorders.

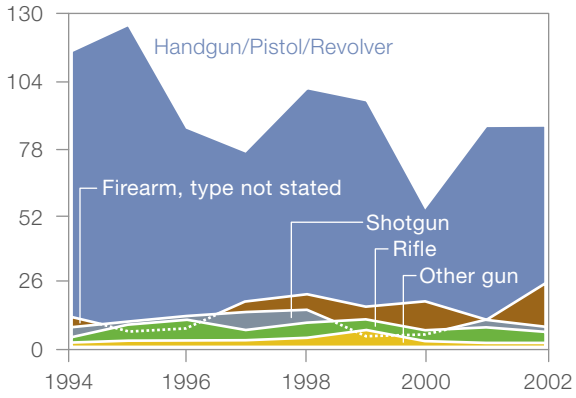
Source: Evaluation data obtained from law enforcement officers and analyzed by the Office of Research and Statistics, Division of Criminal Justice.

[26] Participating law enforcement agencies include the following Police Departments: Arvada, Golden, Lakewood, Westminster, Wheat Ridge, Broomfield, Denver, Cherry Hills, Aurora, Littleton, Englewood, Greenwood Village, Glendale, University of Colorado, Parker, Northglenn, Thornton, Commerce City, Loveland, Ft Lupton, Evans, Firestone, Berthoud, Ault, Ft. Collins, Colorado State University, Vail, Silverthorne, Durango, Pueblo, and Colorado Springs. The following County Sheriffs Offices also participate in CIT: Denver, Arapahoe, Douglas, Elbert, Adams, Pueblo, Jefferson, Larimer, Weld, La Plata, and El Paso.

Project Safe Neighborhood (PSN)

Project Safe Neighborhood is a national program involving a comprehensive and strategic approach to reducing gun crime.

Figure 5.1. Colorado homicides by type of weapon, 1994-2002*



Note: *2002 was the last time the data was displayed this way.

Source: Colorado Bureau of Investigation Supplemental Homicide Reports, 1994-2002.

In Colorado, Project Safe Neighborhood (formerly called Project Exile) is an initiative of the United States Attorney's Office for the District of Colorado. The USAO has formed a partnership among federal, state and local law enforcement officials in conjunction with business and community leaders, with the common goal of reducing gun violence in Colorado.

The PSN message is simple: *Violate federal or state gun laws and you will go to prison*. Gun cases will be referred to the local, state or federal jurisdiction that can pursue the toughest penalty. Most often, this will be federal court. Public awareness campaigns will send the message that gun law violations will not be tolerated and will urge all citizens to report illegal crimes.

Firearm injuries are the second leading cause of death in the United States, killing more than 28,000 people a year since 1972. The cost per firearm fatality is higher than any other type of fatal injury or any other leading cause of death in America.

Source: Violence Policy Center
http://www.vpc.org/studies/firecont.htm.

Community Crime Reduction Theory: By creating these partnerships, the participating agencies and organizations become more effective in developing and implementing comprehensive strategies to reduce youth gun violence.

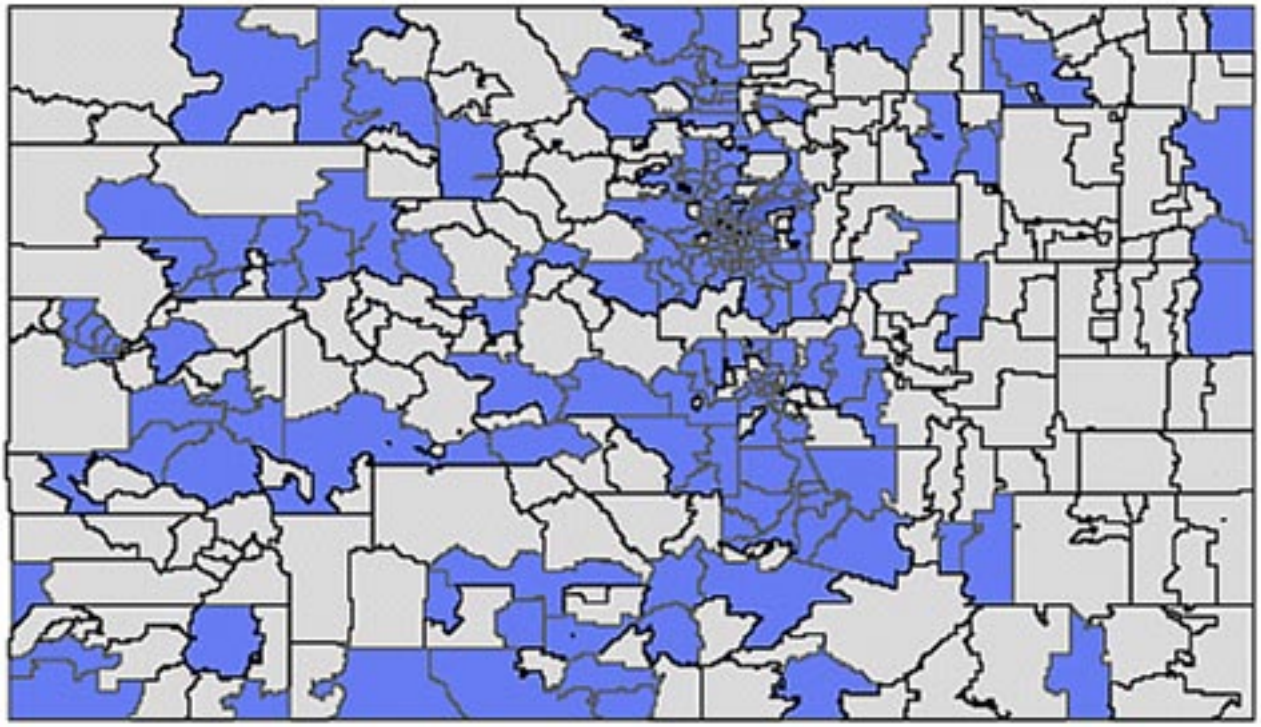
Source: Preventing Crime: What Works, What Doesn't, What's Promising. National Institute of Justice, 1998.

Some objectives of Colorado PSN:

- Increase the number of federal prosecutions of felons in possession of a firearm and the number of state prosecutions of offenders who use guns in the commission of violent crimes and other felonies by coordinating intake of cases with local district attorneys and by encouraging direct referrals from local police.
- Increase the number of federal prosecutions of gun dealer violations and false statements resulting from federal background investigations rejections by working with the Colorado Bureau of Investigation and the Bureau of Alcohol, Tobacco, Firearms, and Explosives to identify, to investigate and prosecute the most serious violations.
- Support the Colorado Springs Gun Interdiction Unit and the Denver Police Department Gun Task Force by assigning an assistant U.S. Attorney liaison to review cases for federal prosecution potential.
- Develop and implement U.S. Attorney's Office policies regarding declination and plea-bargaining which reflect the priority nature of prosecuting gun-law violations.
- Develop and deliver appropriate training programs for local law enforcement regarding the key provisions of federal firearm statutes, investigative guidelines, current federal law governing search and seizure, and federal intake requirements and procedures.
- Work with local business and community leaders to develop and implement an aggressive marketing strategy and publicity campaign.

Colorado has built effective partnerships among local, state and federal law enforcement authorities to ensure the success of PSN. An example of this unprecedented cooperation is the *Colorado Springs Gun Interdiction Program* which combines the enforcement from the Bureau of Alcohol, Tobacco, Firearms and

Figure 5.2. Firearm-related deaths by zip code, 2002 (represented by blue areas*)



Note : *The blue in this map represents zip code areas where one or more firearm-related deaths occurred in Colorado in 2002. These deaths are distributed throughout the state and include both unintentional and intentional deaths.

Source: Colorado Department of Public Health and Environment, available at http://www.cdphe.state.co.us/stats.asp.

Explosives, Colorado Springs Police Department, and El Paso County Sheriff's Office, the prosecution from the United States Attorney's Office, Colorado's 4th Judicial District Attorney's Office, and Crime Stoppers for public awareness and anonymous tips. Together, the efforts of the Colorado Springs Gun Interdiction Program resulted in 1250 felony arrests, 2300 firearms seized, 350 federal defendant case filings and 650 state case filings since its inception in 1999. Furthermore, assaults by firearms are down 40 percent from 1999.

The following table displays the changes over time in the number of defendants charged with federal firearm violations from 1999 through 2004. The majority of defendants were charged with "felon in possession of a firearm" and the use of a firearm during the commission of a drug trafficking offense.

Nearly 800 defendants in the District of Colorado had the following outcomes:

- 590 guilty dispositions
  - *562 pleas,*
  - *28 trials,*
  - *Average sentence of six years,*
  - *Two defendants received life sentences,*
  - *49 were sentenced to home detention/probation,*
- 85 case dismissals, and
- 11 acquittals.

Although the federal prosecution statistics are rising, it is difficult to measure the direct impact of PSN. Homicide rates in Colorado have been generally declining for 25 years, despite peaks in the early 1980's and the early-to-mid 1990's.

Table 5.4. Number of federal firearm violations: U.S. Attorney's Office, District of Colorado

	1999	2000	2001	2002	2003	2004
Number of defendants charged	106	127	127	118	172	173

Source: Dick Weatherbee, Colorado U.S. Attorney's Office.

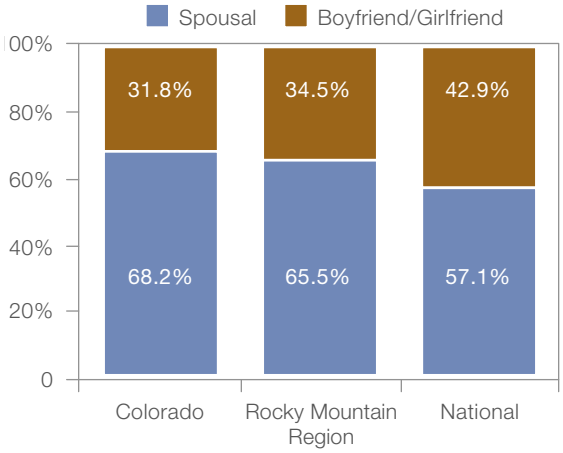
Terrorism at home: Firearms and domestic violence

Firearm-related domestic assaults are 12 times more likely to be fatal than domestic assaults not associated with a firearm.

- In 2000, 58 percent of intimate partner homicide victims were killed with guns and 74 percent of these victims were killed with handguns.
- Nationwide in 2000, there were 331 women shot and killed by either their husband or intimate acquaintance during the course of an argument – nearly one woman a day.
- Firearms were the most common weapons used by males to murder females in 2000.
- The majority of murder-suicides in the United States are firearm-related. Colorado had twenty incidents in a six month period in 2001.
- The number of females shot and killed by their husband or intimate acquaintance (557 victims) was nearly four times higher than the total number murdered by male strangers using all weapons combined (142 victims) in single victim/single offender incidents in 2000. In homicides where males used firearms to kill females, handguns were clearly the weapon of choice over rifles and shotguns.

  Source: (for all above bullets) Violence Policy Center, available at http://www.vpc.org/studies/dv5one.htm.

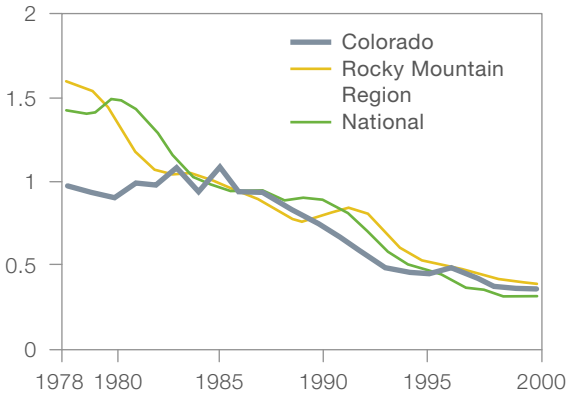
Figure 5.3. Composition of partner homicide: 2000



Source: Elliott, Williams, Mattson, Haag, Cook, 2003.

- The percentage of partner homicide cases in 2000 are displayed in Figure 5.3. Colorado shows a slightly higher percentage of spousal homicide cases compared to regional and national cases.

Figure 5.4. Homicide rates: Spousal partners



Source: Elliott, Williams, Mattson, Haag, Cook, 2003.

- Rates of spousal homicide per 100,000 people from 1978 to 2000 showed a decrease for all comparison groups. Colorado shows a similar decrease in rates.

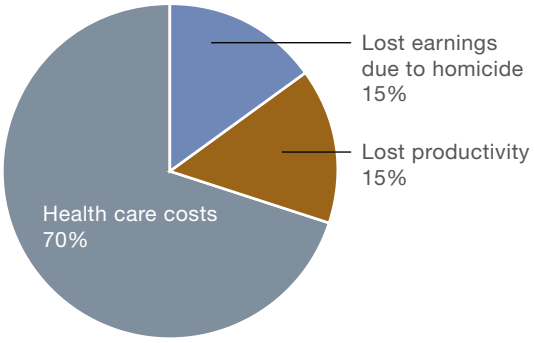
Costs of intimate partner violence in the United States: Nearly $4.1 billion

Understanding the economic costs of intimate partner violence (IPV) can assist policymakers in effective resource allocation. The Centers for Disease Control's Injury Center has calculated the cost of IPV. The estimates provided here include annual costs of the following:

- Direct costs (actual dollar expenditures; the unit cost of a particular service was multiplied by the number of times that service was used).
  - *Hospital emergency department visits,*
  - *Hospitalizations,*
  - *Outpatient clinic visits,*
  - *Services of physicians,*
  - *Dentists,*
  - *Physical therapists,*
  - *Mental health professionals,*
  - *Ambulance transport, and*
  - *Paramedic assistance.*
- Indirect costs due to illness, injury or disability (lost productivity from both paid work, household chores, and present value of lifetime earnings for victims of fatal IPV).
  - *Lost productivity – number of days victims were unable to perform paid work/household chores, using data from the U.S. Bureau of Labor Statistics and the U.S. Census.*

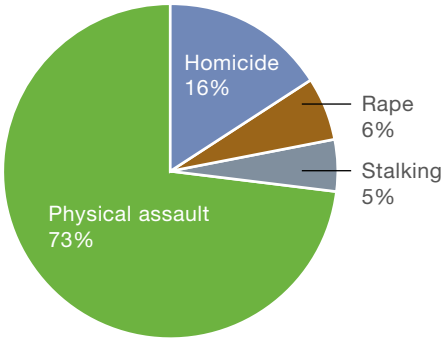
- *Calculations account for differential life expectancy by age group, labor force earning patterns, participation rates at successive ages, and imputed household production values.*

Figure 5.5. Percentage costs of intimate partner violence by cost type,1995



Source: See sources at bottom of this page.

Figure 5.6. Percentage of costs of intimate partner violence by crime type, 1995



Source: See sources at bottom of this page.

2003 Youth Risk Behavior Survey results

A Youth Risk Behavior Survey was conducted on a sample of Colorado high school students in 2003. One of the survey questions asked if they had ever been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months.

Table 5.5. Percentage of students who were ever hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the past 12 months (n=743)

	Total	Males	Females
Total	10%	8.7%	11.3%
Age			
15 or younger	11.1%	11.7%	10.8%
16 or 17	8.8%	5.8%	12%
18 or older			
Grade			
9th	11.3%		12.2%
10th	9.7%	8.3%	11.4%
11th	9.2%		
12th	7.3%		
Race/Ethnicity			
African American			
Hispanic/Latino	13.4%		
White	6.9%	5.6%	8.2%
All other races			
Multiple race			

Note: Blank/shaded cells reflect too few cases to calculate a valid percentage.

Source: 2003 Youth Risk Behavior Survey Results from the Colorado Department of Public Health and Environment available at http://www.cdphe.state.co.us/hs/yrbs/2003COH%20Summary%20Tables.pdf.

Sources: The Centers for Disease Control and Prevention at www.cdc.gov/ncipc/pub-res/ipv_cost/04_costs.htm; Miller, T. (1997). Unpublished data on the value of household production. Landover (MD), National Public Services Research Institute; Bardwell Consulting, Ltd. (2001). Unpublished data for task order 0621-15, funded by the Centers for Disease Control and Prevention; Rice, D., Max, W., Golding, J., and Pinderhuges, H. (1997). *The cost of domestic violence to the health care system*. Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; Tjaden, P. and Thoennes, N. (1999). *Prevalance, incidence and consequences of IPV against women: Findings from the National Violence Against Women Survey*, unpublished report for the National Institute of Justice and the Centers for Disease Control and Prevention.

At least half of those arrested in Denver need drug treatment

Between 1989 and 2003, the Colorado Division of Criminal Justice's Office of Research and Statistics (ORS) participated in the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) project by interviewing men and women booked into the Denver City Jail. This research program studied trends in drug use among arrestees in urban areas. The data have been a central component in studying the links between drug use and crime. Each year, approximately 1,000 arrestees were asked about their illegal drug use and more than 95 percent provided a urine sample upon request. About 25 percent were women. Along with drug use information, the data also estimate the arrestees' risk for drug and alcohol dependence, and history of substance abuse treatment.

Below is a summary of information obtained from Denver arrestees between 2000 and 2002.

Urinalysis results

Table 5.6. Denver City Jail: Urinalysis results, 2000-2002

	2000		2001		2002	
Positive for:	**M***	**F***	**M**	**F**	**M**	**F**
Marijuana	42%	34%	40%	32%	40%	33%
Cocaine	34%	46%	33%	44%	32%	44%
Opiates	4%	6%	5%	2%	4%	5%
Meth-amphetamines	3%	5%	3%	4%	4%	7%
Phencyclidine	0.20%	0%	0%	0%	1%	1%

Notes: *M=Male, F=Female

Source: ADAM data obtained by http://www.adam-nij.net. Analysis performed by Office of Research and Statistics, Colorado Division of Criminal Justice.

Men

- During 2000-2002, approximately 45 percent of a sample of men booked into the Denver City Jail tested positive for at least one drug.
- Twenty-two percent of men tested positive for multiple drugs.
- About 41 percent of men tested positive for marijuana, 33 percent tested positive for cocaine, 4 percent tested positive for opiates, 3 percent tested positive for methamphetamines, and .3 percent tested positive for PCP.

Women

- During 2000-2002, about 45 percent of a sample of women booked in to the Denver City Jail tested positive for one drug.
- Twenty-four percent tested positive for multiple drugs.
- Nearly 33 percent tested positive for marijuana, 45 percent tested positive for cocaine, approximately 4 percent tested positive for opiates, and 5 percent tested positive for methamphetamines. Less than 1 percent of women tested positive for PCP.

45 percent of a sample of both men and women booked into the Denver City Jail tested positive for at least one illigal drug, typically marijuana or cocaine.

Dependency

The interview questionnaire included a screening tool to assess risk for drug and alcohol abuse and dependence to measure the need for treatment. Answering "yes" to a combination of two questions indicates risk for abuse, while answering yes to a combination of three of more questions indicates dependence.[27] The questionnaire also included questions about arrestees' treatment history in an attempt to determine whether they had prior drug or alcohol treatment and, if so, whether they received such treatment in the prior year.

Table 5.7. Risk of drug and alcohol abuse and dependency, 2000-2002

	2000		2001		2002	
At risk for:	**M***	**F***	**M**	**F**	**M**	**F**
Alcohol abuse	15%	13%	15%	10%	17%	10%
Alcohol dependency	55%	57%	48%	54%	50%	54%
Drug abuse	17%	15%	16%	11%	19%	14%
Drug dependency	46%	58%	54%	60%	50%	55%

Notes: *M=Male, F=Female

Source: ADAM data obtained by http://www.adam-nij.net. Analysis performed by Colorado Division of Criminal Justice.

[27] ADAM 2000 Annual Report available at http://www.ncjrs.org/pdffiles1/nij/193013b.pdf.

Men

- About 15 percent and 17 percent of men booked into the Denver City Jail between 2000-2002 were at risk for alcohol abuse and drug abuse, respectively.
- About half of the men were at risk for alcohol dependency and drug dependency.
- Men were more likely than women to be at risk for substance abuse.

Women

- About ten percent and 14 percent of women booked into the Denver City Jail between 2000-2002 were at risk for alcohol abuse and drug abuse, respectively.
- About half of the women were at risk for alcohol dependency and drug dependency.
- Women were more likely than men to be at risk for drug dependency.

Treatment

- One-third of men and women booked into the Denver City Jail between 2000-2002 had experienced inpatient treatment.
  - *Approximately 13 percent of these men and 15 percent of the women reported participation in inpatient treatment the year prior to the current arrest.*
- About 20 percent of the men and 23 percent of the women reported participating in an outpatient drug treatment program.
  - *For both men and women, about half reported recently receiving outpatient treatment in the past 12 months.*

Approximately half of both men and women booked into the Denver City Jail had participated in outpatient drug or alcohol treatment in the past year.

Table 5.8. Participated in inpatient treatment, 2000-2002

	2000		2001		2002	
Time spent in inpatient treatment:	**M***	**F***	**M**	**F**	**M**	**F**
No time	86%	83%	89%	84%	88%	91%
One month or less	6%	9%	6%	7%	6%	5%
1-2 months	3%	2%	2%	3%	3%	3%
3 months or more	5%	6%	4%	7%	4%	2%

Notes: *M=Male, F=Female

Source: ADAM data obtained by http://www.adam-nij.net. Analysis performed by Colorado Division of Criminal Justice.

Table 5.9. Participated in outpatient treatment, 2000-2002

	2000		2001		2002	
Time spent in outpatient treatment:	**M***	**F***	**M**	**F**	**M**	**F**
No time	93%	92%	89%	84%	93%	92%
One month or less	3%	2%	6%	7%	3%	4%
1-2 months	1%	1%	2%	3%	1%	1%
3 months or more	4%	5%	4%	7%	3%	4%

Notes: *M=Male, F=Female

Source: ADAM data obtained by http://www.adam-nij.net. Analysis performed by Colorado Division of Criminal Justice.

What works for drug and alcohol treatment?

13 research-based principles of drug addiction treatment

1. **No single treatment is appropriate for all individuals**. Matching treatment settings, interventions and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available**. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use**. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs**. A client may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness**. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the minimum time at which improvement is reached is three months in treatment. Additional treatment can produce further progress toward recovery. Programs must include strategies to engage and keep clients in treatment.

6. **Counseling – individual and group – and other behavioral therapies are critical components of effective treatment for addiction**. In therapy, clients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities and improve problem solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many clients, especially when combined with counseling and other behavioral therapies**. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and for individuals with co-occurring alcohol dependence, for example.

Effectiveness depends on the extent and nature of the client's present problems, the appropriateness of the treatment components and related services used to address these problems, and the degree of active engagement of the individual in the treatment process.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way**. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use**. Medical detoxification safely manages the acute physical symptoms of withdrawl associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective**. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment and interventions.

11. **Possible drug use during treatment must be monitored continuously**. Lapses to drug use can occur during treatment. The objective monitoring of

a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to those who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection**. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment**. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

Source: (for the 13 principles) National Institutes of Health, October 1999, Publication No. 99- 4180.

Why can't drug addicts quit on their own?

Research has shown that long-term drug use results in significant changes in brain function that persists long after the individual stops using drugs. These drug-induced changes in brain function may have behavioral consequences, including the compulsion to use drugs despite adverse consequences. In fact, this is the defining characteristic of addiction.

Understanding that addiction has a biological component may help explain an individual's difficulty in achieving and maintaining abstinence without treatment. Psychological stress, social cues (such as meeting individuals from one's drug-using past), or the environment (such as encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder attainment of sustained abstinence and make relapse more likely. Research studies indicate that even the most severely addicted individuals can participate actively in treatment and that active participation is essential to good outcomes.

How effective is drug treatment?

In addition to stopping drug use, the goal of treatment is to return the individual to productive functioning in the family, workplace, and community. Measures of effectiveness typically include levels of criminal behavior, family functioning, employability, and medical condition. Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma.

Studies show drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. For example, one study of a therapeutic community treatment for drug offenders demonstrated that arrests for violent and nonviolent criminal acts were reduced by 40 percent or more. Methadone treatment has been shown to decrease criminal behavior by as much as 50 percent. Treatment can improve the prospects for employment, too, with gains of up to 40 percent after treatment.

Is drug addiction treatment worth its cost?

Drug addiction treatment reduces associated health and social costs. Some studies have estimated that for every $1 invested in addiction treatment program, there is a $4 to $7 reduction in thefts, drug-related crime and criminal justice costs. Health care savings can exceed costs by a ratio of 12 to 1.

Sources:

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The economic cost of drug abuse in the United States in 2002 was $181,000,000,000

- Almost 60 percent of these costs are attributed to crime-related drug abuse.
- The costs of drug abuse increased an average of 5.3 percent each year between 1992 and 2002.
- The most rapid increases in drug abuse costs have been in the criminal justice system, particularly the increased rates of incarceration for drug offenses and drug-related offenses, and increased spending on law enforcement and adjudication.
- During the same period, health care, treatment and prevention costs have increased only moderately.
- The largest proportion of costs is from lost potential productivity.
  - *The loss of productivity was estimated at $128.6 billion in 2002, up from $77.4 billion in 1992.*
  - *This loss is attributed in large part to 660,000 offenders incarcerated for drug and drug-motivated crimes.*
    - > *This loss was estimated at 1 million person years.*

Cost to the nation

Drug Abuse:	*$124.9 billion in1995*
Alcohol Abuse	*$184.6 billion in 1998*
Smoking	*$138 billion in 1995*
Heart Disease:	*$183.1 billion in 1999*
Cancer	*$ 96.1 billion in 1990*
Diabetes	*$ 98.2 billion in 1997*
Alzheimer's	*$100 billion in 1997*
Stroke	*$43.3 billion in 1998*
Mental Illness	*$160.8 billion in 1992*

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

- These estimates are conservative in that they make no allowances for the impact of drug abuse on the quality of life of the family, neighbors, crime victims of drug abusers or on the drug abuser her/himself. When such factors are included in economic valuation studies, the cost estimates are typically several times greater than the productivity losses.

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