Section 7: Special Features

Crime is a complex social problem that cannot be understood without a broad base of information. This section provides brief discussions of a variety of issues relevant to criminal and juvenile justice in Colorado.

- Children of incarcerated parents
- Criminal behavior is linked to low school achievement
- Childhood abuse and neglect and later criminal behavior
- School violence
- Trends in drug use among high school students and youth
- Methamphetamine use in Colorado
- Why do people involved in the criminal justice system continue abusing drugs?
- Principles of drug abuse treatment for criminal justice populations
- Preliminary outcomes of domestic violence offenders treated in Colorado
- Offenders with mental illness in prison administrative segregation

Children of incarcerated parents

Children of incarcerated parents are seven times more likely to become involved in the juvenile and adult criminal justice system (Gabel and Shinkledecker, 1993). Lacking the support of families, schools, and other community institutions, they often do not develop values and social skills leading to the formation of successful relationships.

On any given day in the United States, there are over two million minor children with an incarcerated parent. About three quarters of all female prisoners and two thirds of all male prisoners are parents with an average of 2.4 and 2.0 children each, respectively. Eighty-five percent of the children who have a mother in prison are under the age of 10. Another six percent of women entering prison are pregnant.

Although there are no statistics specific to Colorado, using these averages obtained from national statistics from the Bureau of Justice Statistics (Greenfeld and Snell, 1999), Bosley, Donner, McLean, and Toomey-Hale (2002) estimated at least 2,500 children in Colorado have a mother in prison and 13,000 children in Colorado have a father in prison. In total, a minimum of 15,500 children currently have a parent in prison. Certainly, a much larger number have experienced the incarceration of a parent at some point in their lives.

Activities in Colorado addressing parental incarceration

The Colorado Criminal Justice Reform Coalition published a handbook, *Parenting From Prison*, and over 15,000 copies were distributed to inmates and parolees in 2004. Abundant Life Baptist Church and True Light Baptist Church in Denver both provide after-school programs for children of incarcerated parents. The Colorado Office of Child Support Enforcement works with the Department of Corrections to enable prisoners to use money from personal inmate accounts to pay child support. This reinforces the message to parents that incarceration does not mitigate their child support responsibilities.

The Colorado Division of Child Welfare trains caseworkers to understand that these children require that their families receive special services designed to help break the parents' cycle of recidivism and prevent children from following in their parents' footsteps. The Division of Child Welfare identifies the following caseworker activities as key components of providing services to this population of youth:

- ***Work collaboratively to find services*** to enable the parent who is incarcerated to assist in addressing child safety and permanency.
- ***Know what services are available inside the prison and how to access them.*** Use personal contacts at the prison as well as any printed material to discover any special services, such as substance abuse treatment, parenting classes, or educational opportunities (Katz, 1998). Know the requirements for participation and support the parent in meeting those requirements as appropriate.
- ***Collaborate with other organizations to provide services not available within the prison.*** Other community groups may be able to provide such services as transportation to the facility, support for caregivers, or support for the parent.
- ***Work with prison case managers to provide coordinated services for children and parents.*** Work with the correctional staff around holistic planning and service provision so that permanency planning services and rehabilitation services are complementary in preparing the parent for eventual reentry into the community.
- ***Support the parent and caregiver in working together to meet the needs of the child.*** For instance, suggest that the caregiver consult with the parent about how to address the child's behavior problems or what supplies are needed for school.
- ***Empower the parent who is incarcerated to make decisions or influence decision-making*** such as who should care for the children or what services will fit best for his or her situation. When kin take on parenting responsibilities, it might be beneficial to help parents in prison identify outside support resources so that they do not inadvertently overload the kin caregiver.
- ***Engage in family group decision-making*** to bring all the key individuals to one place to creatively problem-solve and make joint decisions for the children.

Further, the American Correctional Association, the American Humane Association, and the Child Welfare League of America have made the issue of children having incarcerated parents an organizational priority. The numbers of books and resources addressing this issue have increased significantly since the mid-1990s when female incarceration rates began to escalate. The U.S. Department of Health and Human Services (DHH) recommends mentoring as a successful approach to increasing positive outcomes for this at-risk juvenile population. For over 30 years, the Family and Youth Services Bureau (FYSB) within the Administration for Children and Families (ACF) in DHH has provided grants at the local level to community and faith-based organizations serving a population of vulnerable youth, including runaway, homeless, and street youth.

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Bosley, B., Donner, C., McLean, C., and Toomey-Hale, E, (Eds.) (2002). *Parenting From Prison – A Resource Guide for Parents Incarcerated in Colorado*. Parenting from Prison Guide Committee. Denver, Colorado.

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Criminal behavior is linked to low school achievement

Nearly one-third of all public high school students—and nearly one-half of all African American, Hispanic and Native American youth—fail to graduate from public high school with their class.[1] Additionally, dropouts are more likely than high school graduates to be unemployed, in poor health, living in poverty, on public assistance, and be single parents with children who also drop out of high school.[2]

Dropouts are more likely than high school graduates to be unemployed, in poor health, living in poverty, on public assistance, and be single parents with children who also drop out of high school.

A new cost-benefit study estimates that each new high school graduate would yield a public benefit of $209,000 in higher government revenues and lower government spending for an overall investment of $82,000, divided between the costs of powerful educational interventions and additional years of school attendance leading to graduation. *The net economic benefit to the public purse is therefore $127,000 per student and the benefits are 2.5 times greater than the costs.*[3] In fact, the government would reap $45 billion in extra tax revenues and reduced costs in public health, crime, and welfare payments if the number of high school dropouts among 20-year olds in the U.S. today, which numbers more than 700,000 individuals, were cut in half.[4]

How does Colorado rank?

A new national database developed by the U.S. Department of Education ranks Colorado graduation rates much lower than previously recorded. The high school graduation rate for 2002-2003 was 73 percent statewide, according to the National Center for Education Statistics and the Education Research Center. For every 100 students in Colorado in the 9th grade, 91 enter 10th grade, 85 enter 11th grade, 78 enter 12th grade and 73 graduate. Specifically, Denver County graduates only 46.8 percent of every 100 students that enter the 9th grade, according to Education Week Magazine. In addition:

- Colorado ranks 37th among the 50 states for funding K-12.
- Colorado ranks 42nd in the nation for Hispanic graduation rates.
- Colorado ranks 48 out of 50 in funding for higher education.[5]

Table 7.1. Colorado education facts by race/ethnic groups, 1998, 2002, 2003

	Year	White	Hispanic	Black	Asian	Amer. Indian	Total
Public school student enrollment – Percent of total	1998	70.6%	19.9%	5.6%	2.7%	1.2%	**100.0%**
	2002	65.7%	24.3%	5.7%	3.0%	1.2%	**100.0%**
	2003	64.5%	25.3%	5.8%	3.1%	1.2%	**100.0%**
Graduation rate	1998	84.7	63.4	69.1	84.1	56.4	
	2002	86.4	65.5	73.7	86.2	58.3	
	2003	87.5	69.6	76.8	87	65.8	
Dropout rate per 100,000 in this age group (2002 rates include alternative schools)	1998	2.7	6.3	4.6	3	6.6	
	2002	2.2	4.6	3	1.5	5	
	2003	1.7	4.2	3	1.5	3.8	

Source: Data and Research Unit, Colorado Department of Education, available at www.cde.state.co.us/cdereval.

[1] Bridgeland, J.M., Dilulio, J. J., Morison, K.B. (2006). *The Silent Epidemic: Perspectives of High School Dropouts* – calculations based on Harlow, C. W. (revised 2003). *Education and Correctional Populations. Bureau of Justice Statistics Special Report*. Department of Justice. Washington, DC: U.S. Available at: www.ojp.usdoj.gov/bjs/pub/pdf/ecp.pdf.

[2] Available at: http://www.silentepidemic.org.

[3] Henry Levin, H., Belfield, C., Muennig, P., Rouse, C. (2007). *The Costs and Benefits of an Excellent Education for All of America's Children*, Center for Cost-Based Studies, Columbia University, available at www.CBCSE.org.

[4] Henry Levin, H., Belfield, C., Muennig, P., Rouse, C. (2007). *The Costs and Benefits of an Excellent Education for All of America's Children*, Center for Cost-Based Studies, Columbia University, available at www.CBCSE.org.

[5] State Accountability Report 2005-2006 School Year, Colorado Education Index. Available at: http://www.reportcardcolorado.com/Files/ReportCard_2006.pdf. Also see www.edweek.org/rc.

For every 100 students in Colorado in the 9th grade, 91 enter 10th grade, 85 enter 11th grade, 78 enter 12th grade and 73 graduate. (Source: www.edweek.org/rc.)

Dropout rates effect on crime

Dropouts are more than eight times as likely to be in jail or prison as high school graduates.[6] Studies show that the lifetime cost to the nation for *each* youth who drops out of school and later moves into a life of crime and drugs ranges from $1.7 to $2.3 million.[7] The relationship between crime and education is clearest when looking at dropout status and incarceration: although they constitute less than 20% of the overall population, dropouts make up over 50% of the state prison inmate population.[8] Overall serious crime rates are reduced by 10-20% with a high school education. This reduction in crime is assumed to have a corresponding effect on incarceration rates and societal costs.

Certain groups—particularly black males—are disproportionately represented in the prison system, and are disproportionately undereducated.

Victims bear most of the costs of crime, but these are not (directly) counted in the public's balance sheet. From the public perspective, there are four main costs: criminal justice system costs for policing and for trials and sentencing; incarceration costs (including parole and probation); state-funded victim costs (medical care and from lost tax revenues); and expenditures of government crime prevention agencies.[9]

Dropouts are more than eight times as likely to be in jail or prison as high school graduates.

Table 7.2. Criminal activity by age 20

Crime type	Number of crimes	Impact from high school education
Murder	1	-20%
Rape	2.5	-20%
Violent offenses	32	-20%
Property offenses	279	-10%
Drug offenses	600	-12%

Notes: Crimes per 1,000 high school dropouts.

Violent crime includes robbery and aggravated assault. Property crime includes burglary, larceny-theft, arson, and motor vehicle theft. The share of total arrests by high school dropouts is based on incarceration rates.

Sources: Levin, Belfield, Muennig, and Rouse (2007). *The Costs and Benefits of an Excellent Education for All of America's Children*, Center for Cost-Based Studies, Columbia University, available at CBCSE.org; UCR (2004) adjusted for undersurvey; Wolf and Harlow (2003); Lochner and Moretti (2004).

Using Bureau of Justice Statistics data and survey information, researchers at Columbia University calculated the public cost per crime and per arrest for each of five crime types (see Table 7.2). Each crime imposes costs in terms of policing, government programs to combat crime, and state-funded victim costs. Each arrest also imposes costs in terms of trials, sentencing, and incarceration. The costs per crime and arrest vary according to the type of crime (mainly because of differences in prison sentences). The average cost-savings from reduced criminal activity was $26,600 per offender.[10]

More 13 and 14 year olds were arrested in 2003 than scored Advanced on the reading CSAP (9,043 versus 8,463).[11]

[6] Bridgeland, J.M., Dilulio, J. J., Morison, K.B. (2006). *The Silent Epidemic: Perspectives of High School Dropouts* – calculations based on Harlow, C. W. (revised 2003). *Education and Correctional Populations. Bureau of Justice Statistics Special Report*. Department of Justice. Washington, DC: U.S. Available at: www.ojp.usdoj.gov/bjs/pub/pdf/ecp.pdf.

[7] Snyder, H. and Sickmund, M. (1999). *Juvenile Offenders and Victims: 1999 National Report*. Office of Juvenile Justice and Delinquency, U.S. Department of Justice. Washington, D.C.

[8] Bonczar, T.P. (2003). *Prevalence of Imprisonment in the U.S. Population, 1974–2001. BJS Special Report*, Bureau of Justice Statistics, U.S. Department of Justice. Washington, D.C. NCJ 197976.

[9] Henry Levin, H., Belfield, C., Muennig, P., Rouse, C. (2007). *The Costs and Benefits of an Excellent Education for All of America's Children*, Center for Cost-Based Studies, Columbia University, available at www.CBCSE.org.

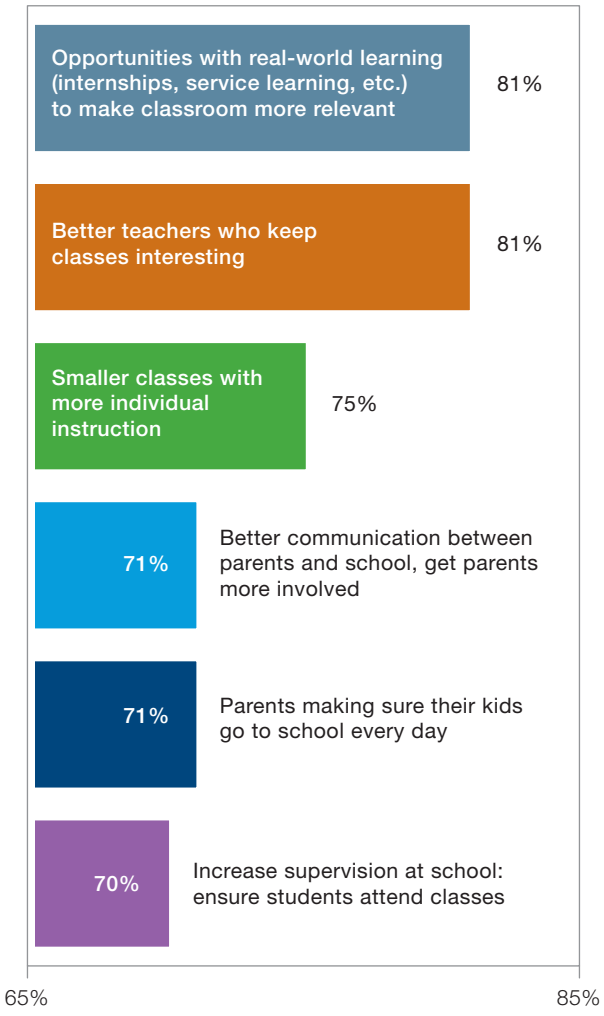
[10] Henry Levin, H., Belfield, C., Muennig, P., Rouse, C. (2007). *The Costs and Benefits of an Excellent Education for All of America's Children*, Center for Cost-Based Studies, Columbia University, available at www.CBCSE.org.

[11] State Accountability Report 2005-2006 School Year, Colorado Education Index. Available at: http://www.reportcardcolorado.com/Files/ReportCard_2006.pdf.

A word from dropouts and students

- Dropouts want to learn in non-traditional ways.
- Dropouts want learning to be interesting.

Figure 7.1. What dropouts believe would improve students' chances



Source: Bridgeland, J.M., Dilulio, J. J., Morison, K.B. (2006). *The Silent Epidemic: Perspectives of High School Dropouts*, a report by Civic Enterprises in association with Peter D. Hart Research Associates for the Bill & Melinda Gates Foundation, report available at http://www.civicenterprises.net/pdfs/thesilentepidemic3-06.pdf.

The Silent Epidemic: The 10-point plan[1]

The Bill and Malinda Gates Foundation asked the Peter D. Hart Research Associates to speak with public high school dropouts to better understand what the researchers concluded is America's ***Silent Epidemic****. Researchers gathered information from more than 500 students in 25 different locations; they reviewed the literature, and they offered recommendations to students, parents, schools, and policymakers.*[2]

1. ***Support accurate graduation and dropout data:*** *Schools and communities cannot adequately address the dropout problem without an accurate account of it. The National Governors Association established a 50-state compact to ensure a common definition for high school graduation rates. States and school districts should set benchmarks for raising graduation rates and should monitor progress toward such goals.*

2. ***Establish early warning systems to support struggling students:*** *Research shows that you can predict with 66% accuracy a student in elementary school who will go on to drop out from high school. Because dropping out of school is a slow process of disengagement for most students, we have an opportunity to identify and address early indicators that signal the need for more support for students to stay in school. High schools need to develop early warning systems to help them identify students who are in need of extra academic or other supports and to have strong partnerships with elementary and middle schools to ensure students stay on track.*

3. ***Provide adult advocates and student supports:*** *Students need adult advocates who can help identify academic and personal challenges early and get students the support they need. Schools need to connect to communities in ways that offer a wide range of supplemental services and intensive*

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assistance strategies for struggling students—attendance monitoring, school and peer counseling, mentoring, tutoring, double class periods, internships, service learning, summer school programs, after school programs, and more—with strong adult advocates who can help identify academic and personal crises early and get students the support they need from schools and communities.

4. ***Support parent engagement and individualized graduation plans:*** *Research shows that parents' engagement in their children's school lives results in multiple benefits to the students, such as improved school attendance, educational performance, classroom behavior, and emotional well-being. Schools should also develop an individualized graduation plan for each student, have the expectation that students will graduate ready for college and the workforce and regularly communicate with parents about progress towards completing such a plan.*

5. ***Establish a rigorous college and work preparatory curriculum for high school graduation:*** *Students taking a rigorous core curriculum in high school are better prepared to succeed in college and in the workforce than students taking less challenging coursework. States and schools need to have high standards for all students and tie high school graduation requirements to the expectations of colleges and employers.*

6. ***Provide supportive options for struggling students to meet rigorous expectations:*** *Student learning needs and styles differ widely; in response, states and districts should develop support options that allow all students to graduate from high school prepared for college and the workplace. These choices may include 9th grade academies that support entering freshmen, second chance schools where student dropouts can continue earning course credit, and other entirely new school models that combine personalized learning environments with high expectations.*

7. ***Raise compulsory school age requirements under state laws:*** *Over the last decade, many states have raised their compulsory school age from 16 to 18, recognizing that a high school education is the minimum required to compete in today's global economy. Research supports the relationship between raising the compulsory school age and reducing the dropout rate.*

8. ***Expand college level learning opportunities in high school:*** *Dual enrollment, early college programs, and Advanced Placement (AP) programs allow high school students to earn credit toward high school and college simultaneously. States and school districts should expand access to these programs.*

9. ***Focus the research and disseminate best practices:*** *The Government Accountability Office noted that while states and school districts have implemented numerous interventions designed to increase high school graduation rates, there has been too little focus at the national level to evaluate and disseminate existing research and best practices. Clearinghouses of well-evaluated best practices should be established to assist states and schools.*

10. ***Make increasing high school graduation and college and workforce readiness a national priority:*** *Local, state and federal policymakers, educators and students should be brought together with experts and innovators through national and state summits, regional and local conferences and public forums in schools and communities to discuss the incidence of, causes of and solutions to the dropout epidemic.*

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[1] From http://www.silentepidemic.org/solutions/index.htm.

[2] The researchers conducted four focus groups of ethnically and racially diverse 16-to 24-year-olds in Philadelphia and Baltimore in August 2005. In September and October 2005, interviews were conducted primarily face to face with 467 ethnically and racially diverse students aged 16 through 25 who had dropped out of public high schools in 25 different locations in large cities, suburbs and small towns. These locations were selected from high dropout rate areas with a significant degree of geographic and demographic variation. Sixty-seven percent of the sample consisted of city residents and the remainder were from the suburbs (14 percent) or small towns and rural areas (17 percent).

Childhood abuse and neglect and later criminal behavior

Groundbreaking work by criminologist Cathy Widom, conducted in the early and mid-1990s, documented the relationship between child abuse and neglect and later criminal behavior. Widom (1995) reported that, in general, people who experience *any* type of maltreatment during childhood—whether sexual abuse, physical abuse, or neglect—were more likely than people who were not maltreated to be arrested later in life. This is true for juvenile as well as adult arrests. Twenty-six percent of the people who were abused and/or neglected were later arrested as juveniles, compared with only 16.8 percent of the people who were not. The figures for adults also indicate a greater likelihood of arrest among people who were maltreated during childhood.

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Differences between those who were abused and/or neglected and those who were not were particularly noteworthy for specific crime types. Consider the following findings:

- 14.3 percent of the people who were abused or neglected as children were later charged with property crimes as juveniles, while this was true for only 8.5 percent of the controls.
- More than 8 percent of the individuals abused or neglected as children were arrested for these offenses as adults, compared to only 5.2 percent of the control group.
- A similar difference in the rate of property crime arrests was found among adults.
- Experiencing any type of abuse/neglect in childhood increases the risk for sex crimes:[12] Among sexually abused children, the odds of being arrested for a sex crime as an adult were 4.7 times higher than the control group; among physically abused children the odds were about 4 times higher, and among neglected children, the odds of a subsequent arrest for a sex crime was 2.2 times that of the control group.
- Among children who were sexually abused, the odds of being arrested for prostitution as an adult are 27.7 times higher than for the control group.

Among children who were sexually abused, the odds of being arrested for prostitution as an adult are 27.7 times higher than for the control group.

The link between early childhood sexual abuse and later delinquent and adult criminal behavior is not inevitable. Although it is clear that individuals who were sexually abused in childhood are at increased risk of arrest as juveniles and adults, many do not become delinquents or adult criminals. In fact ***the majority of the sexually abused children in this study do not have an official criminal history as adults***. Long-term consequences of childhood sexual abuse may be manifest across a number of domains of psychological distress and dysfunction, but not necessarily in criminal behavior. Delinquency and criminality represent only one possible type of outcome of childhood sexual abuse. A number of researchers have described depression, anxiety, self-destructive behavior, and low self-esteem among adults who were sexually abused in childhood.

It is relevant to note that additional research has demonstrated that youths who engage in high levels of antisocial behavior are much more likely than other youths to have a biological parent who also engages in antisocial behavior. This association is believed to reflect both the genetic transmission of predisposing temperament and the maladaptive parenting of antisocial parents.

Prevention and intervention

Several effective programs and strategies to prevent youth violence have been developed and tested in recent years. For pre-school children, the Nurse Home Visitation Program, partly funded by the National Institute of Mental Health (NIMH), is a 20-year model of research in which nurses visit mothers beginning during pregnancy and continuing through their child's second birthday to improve pregnancy outcomes, promote children's health and development, and to strengthen families' economic self-sufficiency. This pro-

[12] Note that sex crimes in this study include prostitution, incest, child molestation, rape, sodomy, assault and battery with intent to gratify, peeping, public indecency, criminal deviant conduct, and contributing to the delinquency of a minor.

The National Institute of Mental Health has summarized findings from early childhood research on trauma that suggest that traumatic stress can result in failure of biologic systems essential to a person's management of stress response, arousal, memory, and personal identity. These system failures can affect functioning long after acute exposure to the trauma has ended. One might expect that the consequences of trauma can be even more profound and long lasting when they influence the physiology, behavior, and mental life of a developing child or adolescent.

gram, currently underway in New York, Colorado,[13] and Tennessee, appears to benefit high-risk families, particularly low-income unmarried women, reducing rates of childhood injury, child abuse and neglect, and other risk factors for early-onset antisocial behavior in children. Long-term follow-up of the children in two of the studied locations indicated that by age 15, the following positive outcomes were documented:

- Compared to a randomly assigned comparison group, participants had fewer
- Behavioral problems related to the use of drugs and alcohol,
- Fewer instances of running away,
- Fewer arrests and convictions, and
- Fewer sexual partners.

The NIMH notes on its website devoted to child and adolescent violence that Hawaii's Healthy Start Program is designed to prevent child abuse and neglect and promote child health and development in newborns of families classified as highly stressed and/or at risk for child abuse and neglect. Following a successful pilot study, this program is now operating statewide and has inspired adaptations in other locations. The program uses a home visitation model to help family members cope with the challenges of child rearing, to teach effective parenting and problem-solving skills, and to link families to necessary services such as childcare, income and nutritional assistance, and pediatric primary care. After two years of service, mothers reported improved parenting efficacy, decreased parenting stress, more use of non-violent discipline, better linkage with

Prenatal and Infancy Nurse Home Visitation Program

The Prenatal and Infancy Nurse Home Visitation Program is operated by the University of Colorado Health Sciences Center. This evidence-based program, and two others like it, has been the subject of several evaluations, including one that followed participants for 15 years. Economists estimate that mothers averted from crime by this program produce a cost benefit per participant (benefits minus costs) of $14,283. Economists estimate that children averted from later criminal behavior produce a cost benefit per participant of $12,822, for a total savings of at least $27,000 per intervention; this is higher when more than one child per mother is involved. This program has been tested in urban and rural settings with both white and African American families. Program cost is estimated at approximately $3,200 per family. The University of Colorado Center for the Prevention of Violence reports the following additional outcomes:

- *79% fewer verified reports of child abuse or neglect;*
- *44% fewer maternal behavioral problems due to alcohol and drug abuse;*
- *69% fewer maternal arrests;*
- *60% fewer instances of running away on the part of children;*
- *56% fewer arrests on the part of children;*
- *56% fewer days of alcohol consumption on the part of children.*

Source: Aos, S., Miller, M. and Drake, E. (2006). *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Washington State Institute for Public Policy, Olympia, Washington; University of Colorado, Center for the Study and Prevention of Violence, at www.colorado.edu/cspv/blueprints/model/programs/NFP.html.

[13] The well-known program in Colorado is located at the University of Colorado Health Sciences Center in Denver.

Parenting training can help

Parental behavior can also either increase or decrease an adolescent's risk for delinquency and other problem behaviors (Elliott, Huizinga, and Menard, 1989; Loeber and Stouthamer–Loeber, 1986; Patterson et al., 1992; Sampson and Laub, 1993; Simons et al., 1998; Simons, Chao, and Conger, 2001). Volumes of research indicate that supportive parent–child relationships, positive discipline methods, close monitoring and supervision, parental advocacy for their children, and parental pursuit of needed information and support (Huizinga, Loeber, and Thornberry, 1995; Bry, 1996; Alvarado and Kumpfer, 2000) consistently buffer youth against problem behaviors. The following specific factors have all been found to influence delinquent behavior:

- *Antisocial behavior of parents (Slavin and Rainer, 1990; Henggeler, 1989);*
- *Unsupportive parents (Conger and Simons, 1997; Sampson and Laub, 1993; Gottfredson and Hirschi, 1990);*
- *Physical and emotional abuse (Doerner, 1987);*
- *Parent–child involvement, parental supervision, and parental rejection (Loeber and Stouthamer–Loeber, 1986; Cernkovich and Giordano, 1987);*
- *And parental monitoring, parenting techniques, and caretaker discipline toward children (Steinberg, 1990; Snyder and Patterson, 1987).*

Consequently, parent training is considered by the federal Office of Juvenile Justice and Delinquency Prevention to be a core response to juvenile behavior problems. Parent training programs are administered in a variety of ways including behavioral parent training, parent education, parent support groups, in-home parent education or parent aid, and parent involvement in youth groups.

Numerous researchers have found that parent training helps reduce aggressive, antisocial, and delinquent behavior among children (Dumas, 1989; Satterfield et al., 1987; Tremblay et al., 1991; Tremblay et al., 1992; Kazdin, Siegel, and Bass, 1992). For instance, the Parent–Child Development Center Program is an intervention that targets low-income families in which mothers are the primary caregivers of children ages 2 months to 3 years. The intervention includes a broad range of support services for mothers and children. Mothers are educated in socio-emotional, intellectual, and physical aspects of infant and child development; receive training in home management; and become familiar with community resources. Several evaluations of this program found that participating 3-year-old children showed increases in IQ and cognitive ability and that more positive interactions occurred between program mothers and children (Bridgeman et al., 1981; Johnson and Walker, 1987; Johnson and Breckenridge, 1982; Johnson, 1991).

pediatric care, and decreased injury due to partner violence in the home, as compared with a control group.

The Administration on Children, Youth and Families (ACYF) and the NIMH have awarded several research grants as the core component of a new young children's mental health research initiative. This initiative is designed to develop and test applications of theory-based research or state-of-the-art techniques for the prevention, identification, and/or treatment of children's mental health disorders within a Head Start context. Among these are projects to develop screening tools for identifying behavior problems in preschool children, to test the effectiveness of research-based classroom interventions for very young children with serious disruptive behavior problems, and to assess the mental health needs of this vulnerable population.

NIMH summarizes that, as important as the problem of violence is, there will be no quick, inexpensive, and fail-safe solution. Recent years have witnessed a strong growth in our understanding of the risk factors and processes that contribute to and shape child and adolescent antisocial behavior. Yet gaps remain in our scientific understanding of how child, family, school/community, and peer factors interact, and which are the most appropriate targets for prevention and early intervention in different settings. We are also learning that being "at risk" does not doom any one child to become violent; conversely, the apparent absence of certain risk does not necessarily protect any one child from problem behavior. The development of serious behavior problems is best understood as a dynamic interaction between child predispositions and various influences on children's lives

(family, peer, and school/community) that change over critical periods of development.

Successful programs that produce long-term sustained effects may need to involve long-term intense interventions to target the multiple factors that can lead to negative outcomes such as family conflict, depression, social isolation, school failure, substance abuse, delinquency, and violence. According to NIMH, the fundamental premise of some of these interventions—interventions that separate youth with problem behaviors—challenges the policies, programs, and procedures that currently bring problem youth together. Continued research is needed to determine the most appropriate targets for prevention and early intervention that will produce lasting change. Answers are emerging about which programs are most successful, but assessments need to be made about their costs, as well as if they will work for all groups of children and adolescents.

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School violence

The Center for Disease Control has been surveying adolescents in high schools since 1993. The project is called the National Youth Risk Behavior Survey (NYRBS). In 2003, the NYRBS obtained thousands of completed questionnaires from 153 schools. Nearly 1,500 students in Colorado completed questionnaires in 2005.

Nationwide, in 2005 6.5 percent of students reported that they had carried a weapon (e.g., a gun, knife, or club) on school property for at least one of the 30 days preceding the survey. This compares to 5.4 percent of Colorado students. Nearly 8 percent in the national survey reported that they had been threatened or injured with a weapon on school property in 2005 compared to 7.6 percent of Colorado students. These findings are similar to those reported in the 2003 survey.

Nationwide, 13.6 percent of high school students reported that they had been in a physical fight on school property one or more times during the 12 months preceding the survey, compared to 21.1 percent of Colorado students. In 2005, 6.0 percent of students reported that they had not gone to school on one or more of the 30 days preceding the survey because they felt they would be unsafe at school or on their way to or from school; in Colorado 4.3 percent of students reported this concern.

The FBI's *Criminal Justice Information Services Division* is preparing a study examining crime in the nation's schools. The objective of the FBI's study is to examine the characteristics of the offenders and arrestees involved in crimes at school and college locations (hereafter referred to as schools) based on the data reported to the FBI's Uniform Crime Reporting Program by state and local law enforcement agencies that submitted incident-based data 2000-2004. Currently, approximately 20 percent of the nation's law enforcement agencies voluntarily report incident based crime data to the FBI. Preliminary findings from this study include the following:

An analysis of *known* characteristics of school crime offenders reported during the 5-year period revealed the following:

- Most offenders (38.0 percent) were 13 to 15 years old. Offenders comprising the second largest age group (30.7 percent) were 16 to 18 years old, followed by those offenders aged 19 years or older (18.2 percent) and those 10 to 12 years old (11.0 percent). Offenders 9 years of age and under accounted for 2.1 percent of the offenders.
- Males accounted for 76.7 percent of offenders who committed school crimes.
- When examining victim-to-offender relationships, *acquaintance* was the most frequently reported relationship type for crime in schools, occurring in 52.1 percent of the instances in which the relationship was known, followed by *otherwise known* (not related) at 24.5 percent.
- Where weapon type was known, the weapon type most frequently reported was personal weapons (hands, fists, and feet, etc.), which comprised 77.5 percent of weapons used in school incidents. Knives accounted for 8.6 percent of the weapon total and guns, 2.7 percent.

Arrestee data revealed the following:

- Overall, the most common offense in which arrestees were involved was simple assault, followed by drug/narcotic violations, which together accounted for more than half (52.2 percent) of the total offenses for which persons were arrested.
- Among the violent offenses in schools for which persons were arrested, 95 percent were assaults, i.e., simple assault, aggravated assault, and intimidation.

Source: Federal Bureau of Investigation, Synopsis of Crime in Schools and Colleges: A Study of National Incident-Based Reporting System (NIBRS) Data (study forthcoming), available at http://www.fbi.gov/ucr/schoolviolence.pdf.

Weapons

Nationwide, 18.5 percent of students reported that they had carried a weapon (e.g., a gun, knife, or club) on one or more days of the 30 days preceding the survey, slightly higher than the 17 percent reported by Colorado students. Nationwide and in Colorado, were significantly more likely to carry a weapon than females.

In Colorado, 8.1 percent of boys (compared to 17 percent in 2003) and less than 1 percent of girls (compared to 1.6 percent in 2003) said they carried a gun on at least one occasion in the last 30 days.

Nationwide, 35.9 percent of students reported that had been in a physical fight one or more times during the 12 months preceding the survey, compared to 32 percent in Colorado; 3.6 percent reported receiving injuries during a fight in the national survey compared to 3.8 percent of Colorado students.

Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5505a1.htm and http://www.cde.state.co.us/cdeprevention/download/pdf/Results_summary.pdf.

Facts about comprehensive school health education:

- *Students who participate in health education classes that use effective curricula increase their health knowledge and improve their health skills and behaviors.*
- *Students who participate in health education classes that use effective curricula decrease risky behaviors relative to the program.*
- *Reading and math scores of third and fourth grade students who received comprehensive health education were significantly higher than those who did not receive comprehensive health education.*
- *Comprehensive health education and social skills programs for high-risk students will improve school and test performance, attendance and school connectedness. In addition, this success was still apparent six years later.*

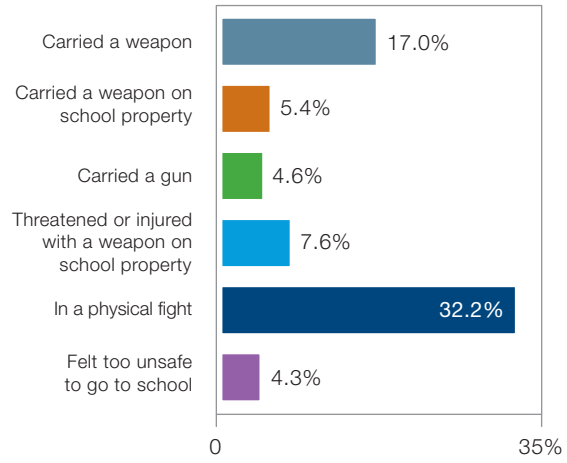
Source: http://www.cde.state.co.us/cdeprevention/eightcomponents.htm.

In the fall of 2006, Colorado participated in a national School Health Profiles survey conducted by the Centers for Disease Control and Prevention. The purpose of this survey is to improve school health programs. Responses from 232 school principals indicated that 39 percent of schools require 2 or more health education courses and 27 percent have a health education coordinator.

For more information, go to http://www.cde.state.co.us/cdeprevention/download/pdf/HIGHLIGHTS_principal_survey.pdf.

Source: Colorado Department of Public Health and Environment, *2005 Youth Risk Behavior Survey*, available at http://www.cdphe.state.co.us/hs/pubs/yrbs2006final.pdf

Figure 7.2. Prevalence of behaviors that contribute to violence, Colorado Youth Risk Behavior Survey (YRBS), 2005



Source: Shupe, Alyson, *Health-Related Behaviors of Colorado Adolescents: Results from the Youth Risk Behavior Survey, 2005*, Colorado Department of Public Health and Environment, available at http://www.cdphe.state.co.us/hs/pubs/yrbs2006final.pdf.

Trends in drug use among high school students and youth[14]

National Data

Since 1975, the Monitoring the Future (MTF) survey has studied annually the extent of drug use among 12th-graders. The survey was expanded in 1991 to include 8th- and 10th-graders. It is funded by NIDA and is conducted by the University of Michigan's Institute for Social Research. The goal of the survey is to collect data on past month, past year, and lifetime[15] drug use among students in these grade levels. The 32nd annual study was conducted during 2006.[16]

Decreases or stability in abuse patterns were noted for most drugs from 2005 to 2006. Below are the key findings, based on data from the 2006 MTF and, in some instances, from other recent MTF survey data. For individual drugs, a decrease or increase is noted only if statistically significant; other trends are considered stable and are not highlighted below.

Positive trends:

- ***Any illicit drug*** – Since the peak years of drug abuse in the mid-1990s, there have been decreases among all three grades in the "any illicit drug" category. Based on 2006 data, past year abuse has fallen by 37 percent among 8th-graders since the peak year in 1996. The peak year for past year abuse among 10th- and 12th-graders was 1997; since then, past year prevalence has fallen by 25 percent among 10th-graders and by 14 percent among 12th-graders. Combining all three grades, past month abuse for any illicit drug has dropped by 23 percent since 2001.
- ***Marijuana*** – Lifetime marijuana abuse decreased among 10th-graders, from 34.1 percent in 2005 to 31.8 percent in 2006. Past year prevalence of marijuana abuse fell by 36 percent among 8th-graders since their peak year of abuse (1996), by 28 percent among 10th-graders, and 18 percent among 12th-graders since their peak year of abuse (1997).

Colorado youth

Table 7.3. Tobacco, alcohol and other drug use, Colorado Youth Risk Behavior Survey (YRBS), 2005

Substance use	Percent
Ever tried ecstasy	6.9%
Ever tried methamphetamine	4.0%
Ever tried inhalants	9.8%
Current cocaine use	2.7%
Ever used cocaine	8.1%
Currently use marijuana	22.7%
Ever used marijuana	42.4%
Binge drinking	30.6%
Currently use alcohol	47.4%
Ever had >1 drink of alcohol	75.9%
Currently smoke cigarettes	18.7%

Note: This table contains information specific to Colorado youth, obtained from the Colorado Youth Risk Behavior Survey (YRBS). The YRBS is one component of the Youth Risk Behavior Surveillance System developed by the Centers for Disease Control and Prevention (CDC) in collaboration with representatives from multiple federal, state, and local departments of education and health. The YRBS is a self-administered, anonymous questionnaire conducted every other year. Students in grades 9-12 who are attending public schools are eligible for participation. Public high schools in Colorado are randomly selected by CDC to participate in the survey process.

Source: Shupe, Alyson. (2005). *Health-Related Behaviors of Colorado Adolescents: Results from the Youth Risk Behavior Survey*. Colorado Department of Public Health and Environment, available at http://www.cdphe.state.co.us/hs/pubs/yrbs2006final.pdf.

- ***Methamphetamine*** – Past year and past month abuse of methamphetamine decreased among 10th-graders from 2005 to 2006 (2.9 percent to 1.8 percent for past year; 1.1 percent to 0.7 percent for past month). Among 12th-graders, perceived risk of harm from trying crystal methamphetamine ("ice") increased from 54.6 percent in 2005 to 59.1 percent in 2006.
- ***Prescription drugs*** – Past year abuse of OxyContin decreased among 12th-graders for the first time since its inclusion in the survey in 2002, from 5.5 percent in 2005 to 4.3 percent in 2006. Perception of harm from trying sedatives/barbiturates "once or twice" increased among 12th-graders, from 24.7 percent in 2005 to 28.0 percent in 2006 (this question is asked only of 12th-graders). This issue is is discussed further under Negative Trends.
- ***Inhalants*** – After some increases in recent years, there were no significant changes from 2005 to 2006 in the proportion of students in the 8th, 10th, and 12th grades reporting lifetime, past year, or past month abuse of inhalants.

[14] Source: National Institute on Drug Abuse, U.S. Departments of Health, http://www.drugabuse.gov/Infofacts/HSYouthtrends.html.

[15] "Lifetime" refers to use at least once during a respondent's lifetime. "Past year" refers to use at least once during the year preceding an individual's response to the survey. "Past month" refers to use at least once during the 30 days preceding an individual's response to the survey. "Daily" refers to an individual's drug use 20 or more times in the 30 days prior to the survey, except for cigarettes, where the definition is one or more cigarettes per day in the 30 days prior to the survey.

[16] For the 2006 MTF, 48,460 students in a nationally representative sample of 410 public and private schools were surveyed about lifetime, past year, past month, and daily use of drugs, alcohol, and cigarettes and smokeless tobacco. The latest data are available at www.drugabuse.gov.

Among 12th-graders, perceived risk of harm from trying crystal methamphetamine ("ice") increased from 54.6 percent in 2005 to 59.1 percent in 2006.

- ***Cigarettes/nicotine*** – Lifetime abuse of cigarettes decreased among 10th- and 12th-graders from 2005 to 2006 (38.9 percent to 36.1 percent for 10th-graders; 50.0 percent to 47.1 percent for 12th-graders). Past year abuse of bidis (small, flavored cigarettes from India) decreased among 12th-graders, from 3.3 percent in 2005 to 2.3 percent in 2006 (this question was asked only of 12th-graders from 2005 to 2006).
- ***Crack cocaine*** – Past year abuse of crack decreased for 10th-graders, from 1.7 percent in 2005 to 1.3 percent in 2006.
- ***Heroin*** – Among 8th-graders, past month heroin abuse decreased, from 0.5 percent in 2005 to 0.3 percent in 2006. Perceived risk of harm from using heroin "once or twice" or "occasionally" increased among 12th-graders from 2005 to 2006. Among 10th-graders, perceived availability of heroin fell, from 19.3 percent in 2005 to 17.4 percent in 2006.
- ***MDMA (Ecstasy)*** – Among 10th-graders, perceived availability of MDMA decreased from 30.2 percent in 2005 to 27.4 percent in 2006 (see also Negative Trends).
- ***Anabolic steroids*** – Among 12th-graders, perceived risk of steroid abuse increased, from 56.8 percent in 2005 to 60.2 percent in 2006 (this question is asked only of 12th-graders).
- ***Alcohol*** – Lifetime and past year abuse of alcohol decreased for 12th-graders from 2005 to 2006 (75.1 percent to 72.7 percent for lifetime; 68.6 percent to 66.5 percent for past year).[17]

Negative trends:

- ***Prescription drugs*** – Past year abuse of OxyContin and Vicodin, first measured in 2002, continued at levels that raise concern. Past year abuse of Vicodin was 3.0 percent among 8th-graders, 7.0 percent among 10th-graders, and 9.7 percent among 12th-graders in 2006, remaining stable but at relatively high levels for each grade. Despite a drop in past year abuse of OxyContin among 12th-graders in 2006, abuse among 8th-graders has nearly doubled since 2002 (from 1.3 percent in 2002 to 2.6 percent in 2006).[18] (See also Positive Trends.)
- ***MDMA (Ecstasy)*** – From 2005 to 2006, the percentage of 8th-graders who saw great risk in using MDMA "once or twice" decreased (40.0 percent to 32.8 percent) as well as using "occasionally" (60.8 percent to 52.0 percent). Also, disapproval of MDMA use decreased among 8th-graders from 2005 to 2006 for trying "once or twice" (75.0 percent to 66.7 percent) and taking "occasionally" (77.9 percent to 69.8 percent).
- ***Hallucinogens*** – From 2005 to 2006, the percentage of 8th-graders decreased who perceived risk of harm from "taking LSD regularly" (44.0 percent to 40.0 percent) and who disapproved of using LSD "once or twice" (58.5 percent to 53.9 percent).

Race/ethnicity differences – key findings for 2006:

(Observed differences between categories have not been evaluated for statistical significance.)

- Among African-American, Hispanic, and white 12th-graders, whites have the highest rates of past year illicit drug abuse.
- Prevalence of past month alcohol abuse is higher among Hispanic 8th-graders than their white or African-American counterparts.

Gender effects – key findings for 2006:

(Observed differences between categories have not been evaluated for statistical significance.)

- Past year use of "any illicit drug" is roughly the same for males and females in the 8th, 10th, and 12th grades.
- Use of "any illicit drug other than marijuana" is slightly higher among females than males in the 8th and 10th grades, but is higher among males in the 12th grade.
- Marijuana abuse is more prevalent among males than females in all three grades.
- There is a continuing pattern of higher abuse rates of OxyContin and Vicodin among males compared with females in the 12th grade.

[17] For information on the health effects of alcohol, visit the Web site of the National Institute on Alcohol Abuse and Alcoholism at www.niaaa.nih.gov.

[18] For more information on the misuse or nonmedical use of pain medications or other prescription drugs, please visit www.drugabuse.gov and click on Prescription Medications under Drugs of Abuse.

Drugs that continue to show a clear gender difference in prevalence of abuse are anabolic steroids and smokeless tobacco (both are more likely to be abused by males than females) and amphetamines and methamphetamine (which are more likely to be abused by females).

Declines and increases from 2005 to 2006:
(Reported differences are statistically significant.)

- ***Females*** – Past year abuse of methamphetamine declined among 10th grade females, from 3.0 percent in 2005 to 2.0 percent in 2006. Past year abuse of MDMA among 12th grade females increased, from 2.7 percent in 2005 to 4.0 percent in 2006.
- ***Males*** – Declines were noted among 10th grade males in past year abuse of methamphetamine, from 2.6 percent in 2005 to 1.7 percent in 2006. Declines were noted among 12th grade males for past year abuse of any illicit drug, from 42.1 percent in 2005 to 37.5 percent in 2006; marijuana, from 37.6 percent in 2005 to 32.7 percent in 2006; OxyContin, from 7.4 percent in 2005 to 5.3 percent in 2006; amphetamines, from 9.1 percent in 2005 to 7.4 percent in 2006; and ice, from 2.5 percent in 2005 to 1.5 percent in 2006. Declines also were noted among 12th grade males for past month prevalence of alcohol abuse, from 50.7 percent in 2005 to 47.3 percent in 2006; binge drinking, from 33.4 percent in 2005 to 29.8 percent in 2006; cigarette abuse, from 24.8 percent in 2005 to 22.4 percent in 2006; daily smoking, from 14.6 percent in 2005 to 12.0 percent in 2006; and smoking a pack or more per day, from 8.0 percent in 2005 to 6.2 percent in 2006.

Source: National Institute on Drug Abuse, U.S. Departments of Health, http://www.drugabuse.gov/Infofacts/HSYouthtrends.html.

Research shows that drug use decreases when drugs are perceived as harmful.

For more information on prevention, see NIDA's most recent edition of *Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*, at www.drugabuse.gov/Prevention/Prevopen.html.

Figure 7.3. Marijuana use by 12th graders, by perceived riskof harm, 1975-2006

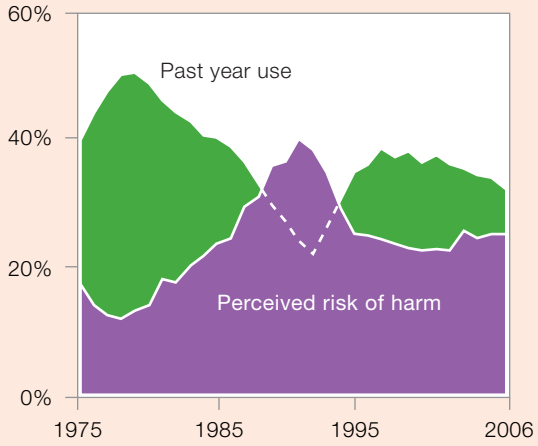
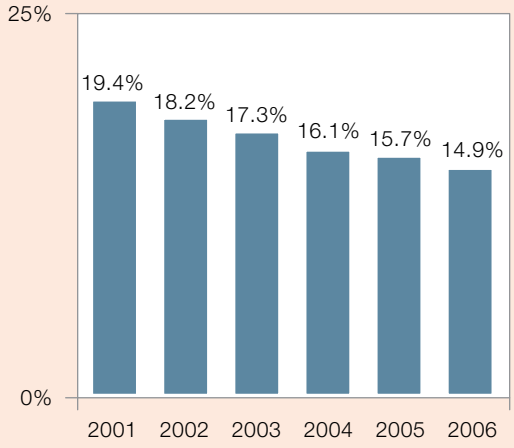


Figure 7.4. Students reporting past month use of any illicit drug, 2001-2006 (8th, 10th, and 12th graders combined)



Source: *2006 Monitoring the Future Survey*, University of Michigan, with funding from the National Institute on Drug Abuse.

Methamphetamine use in Colorado

Extent of the problem

In recent years, methamphetamine (meth) use in Colorado has become an increasingly serious problem. In comparison to other illicit drugs, in 2005 methamphetamine was ranked first in the number of poison control center calls, second in statewide and Denver area treatment admissions, and third in quantity of drug seizures, according to the Community Epidemiology Work Group (CEWG).[19] With respect to drug-induced deaths, the general category of stimulants and methamphetamines was ranked as fourth most frequent. In FY 2005, of the 78,575 discharges from treatment, and detoxification services, 5 percent (4,246) consisted of methamphetamine users. Of the 15,572 first-time drug users discharged from treatment, 17 percent (3,003) reported methamphetamine to be their primary drug, according to the Colorado Department of Human Services Alcohol and Drug Abuse Division (ADAD).[20]

In comparison to other illicit drugs, in 2005 methamphetamine was ranked first in the number of poison control center calls, second in statewide and Denver area treatment admissions, and third in quantity of drug seizures, according to the Community Epidemiology Work Group (CEWG).

In 2005, the rate of self-reported methamphetamine use in Colorado was particularly high in comparison to other states, according to the National Survey on Drug Use and Health (NSDUH).[21] The NSDUH report presented estimates of past year methamphetamine use among persons aged 12 or older in each of the 50 States and the District of Columbia. Based on annual averages of the combined 2002, 2003, 2004, and 2005 NSDUH data, Colorado was ranked

While the number of laboratory closures has increased dramatically since 2002, there has been an increase in the supply of Mexican methamphetamine to compensate for the loss of local production.

16th in terms of self-reported methamphetamine use during the past year. Rates of past year use among persons aged 12 or older were the highest among the neighboring states of Wyoming, New Mexico, Arizona, and Nebraska and lowest among states in the Northeast (Connecticut, Maryland, New Jersey, and New York). The overall findings indicate that methamphetamine use is more prevalent in the west (1.2 percent) in comparison to the midwest (0.5 percent), South (0.5 percent), and northeast (0.1 percent) (the numbers in parentheses are prevalence rates for the total population in those states).

Table 7.4. Percentages of persons aged 12 or older reporting past year methamphetamine use: Top 18 states*

State	Percentage
Nevada	2.02%
Montana	1.47%
Wyoming	1.47%
Idaho	1.24%
Nebraska	1.24%
Oregon	1.24%
Arkansas	1.23%
Arizona	1.22%
New Mexico	1.16%
California	1.13%
North Dakota	1.13%
South Dakota	1.12%
Hawaii	1.09%
Colorado	**1.07%**
Iowa	1.07%
Washington	1.03%
Utah	0.94%
Kansas	0.92%

Source: *Methamphetamine Trend Analysis, 1992-2004*. March, 2005. Alcohol and Drug Abuse Division, Colorado Department of Human Services. Available at http://www.cdhs.state.co.us/adad/PDFs/MethamphetamineTrendAnalysis.pdf.

* Average Percentages over the years 2002, 2003, 2004, 2005.

[19] Community Epidemiology Work Group. (2006). *Epidemiologic Trends in Drug Abuse Advance Report*, National Institute on Drug Abuse. Available at http: //www.drugabuse.gov.

[20] Hoxworth, Tamara. (2006). *Patterns and Trends in Drug Abuse in Denver and Colorado: January-December 2005*. Report prepared for the Colorado Community Epidemiology Work Group (CEWG). Available at http://www.cdhs.state.co.us/adad/PDFs/Drugtrendscewgdec05.pdf.

[21] *National Survey on Drug Use and Health, 2006*. SAMHSA, U.S. Department of Health and Human Services. Available at http://ncadistore.samhsa.gov/catalog/results.aspx?h=drugs&topic=131.

Trend analysis

Nationally, the Substance Abuse and Mental Health Service Association (SAMHSA) in the U.S. Department of Health and Human Services) reports that from 1993 through 2003, the rate of admissions for the treatment of methamphetamine abuse increased from 13 to 56 admissions per 100,000 people aged 12 or older. In Colorado, admissions for stimulant use (i.e., cocaine and methamphetamine) have steadily increased from 1992 to 2004. In contrast, treatment admissions for alcohol have significantly decreased, whereas admissions for marijuana use have remained relatively stable. Stimulants were the primary substance of abuse in 30% of Colorado treatment admissions in 2004, according to ADAD. In 2003, methamphetamine exceeded cocaine in illicit drug treatment admissions and has since remained second to marijuana.[22]

Stimulants were the primary substance of abuse in 30% of Colorado treatment admissions in 2004, according to ADAD.

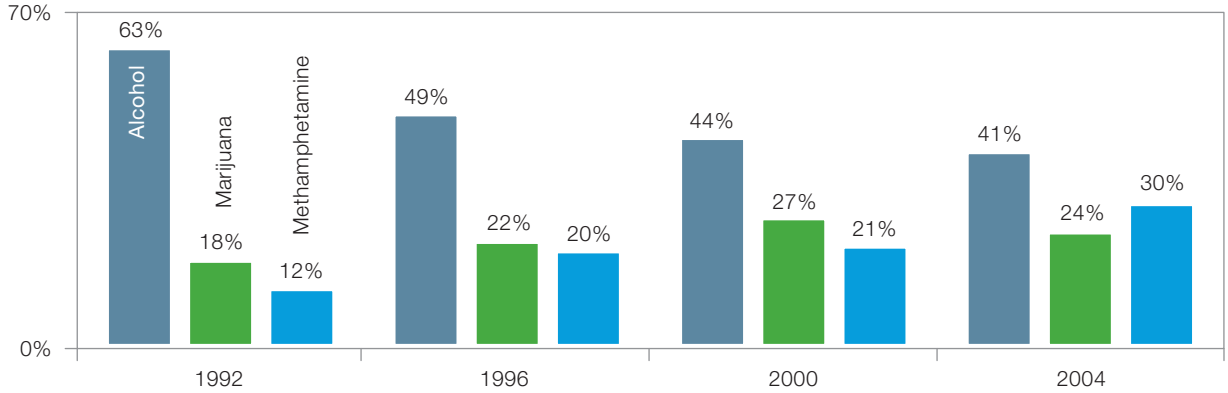
Potential reasons for the increase in methamphetamine use

Methamphetamine is a central nervous system stimulant that has a high potential for abuse and physical dependence.

Long-term use can result in physical problems such as weight loss, decayed teeth, skin lesions, stroke, and heart attack. Methamphetamine users also may experience psychological symptoms such as paranoia, hallucinations, and irritability as well as behavioral symptoms such as aggression and isolation.

According to the Center for Disease Control (CDC), methamphetamine is highly addictive because the drug directly affects the brain and spinal cord by interfering with the normal release and uptake of neurotransmitters (chemicals that nerve and brain cells produce to communicate with each other). The use of methamphetamine causes the release of large quantities of neurotransmitters, especially dopamine. This, in turn, causes increased heart rate, blood pressure, self-confidence, energy, and alertness. These effects, in addition to suppressing appetite and enhancing sexual arousal, are reported by users as their motivation for using methamphetamine. Side effects often reported by users consist of sleeplessness, talkativeness, teeth grinding, and compulsive behavior. Long-term use can result in physical problems such as weight loss, decayed teeth, skin lesions,

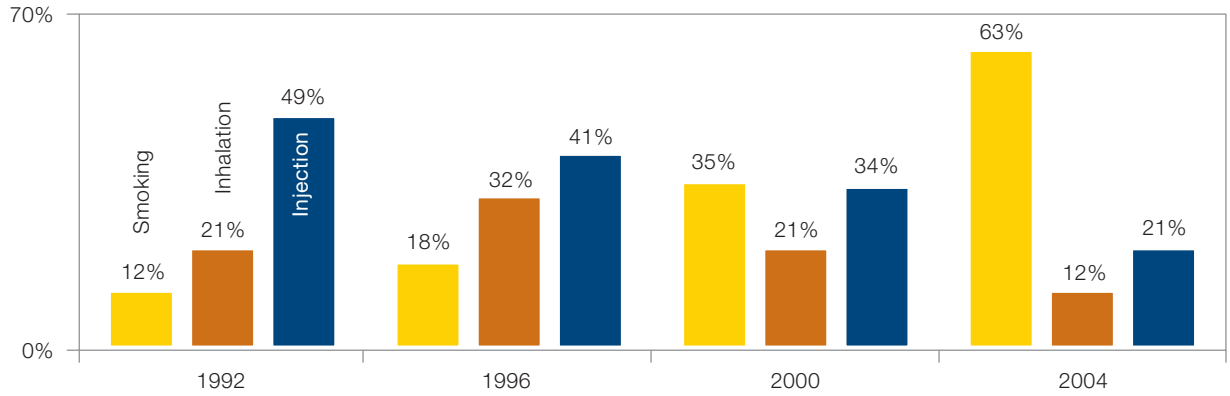
Figure 7.5. Treatment admissions by primary drug type, 1992-2004



Source: *Methamphetamine Trend Analysis, 1992-2004*. March, 2005. Alcohol and Drug Abuse Division, Colorado Department of Human Services. Available at http://www.cdhs.state.co.us/adad/PDFs/MethamphetamineTrendAnalysis.pdf.

[22] *Methamphetamine Trend Analysis, 1992-2004*. March, 2005. Alcohol and Drug Abuse Division, Colorado Department of Human Services. Available at http://www.cdhs.state.co.us/adad/PDFs/MethamphetamineTrendAnalysis.pdf.

Figure 7.6. Methamphetamine treatment admissions, by method of consumption, 1992-2004



Source: *Methamphetamine Trend Analysis, 1992-2004*. March, 2005. Alcohol and Drug Abuse Division, Colorado Department of Human Services. Available at http://www.cdhs.state.co.us/adad/PDFs/MethamphetamineTrendAnalysis.pdf.

stroke, and heart attack. Methamphetamine users also may experience psychological symptoms such as paranoia, hallucinations, and irritability as well as behavioral symptoms such as aggression and isolation. Long-term use of methamphetamine leads to reduced levels of dopamine production, which in turn causes cravings and requires additional doses to increase dopamine levels. This cycle leads to addiction.

According to the National Institutes of Health, as compared to cocaine, methamphetamine causes more than a three-fold release of dopamine in the brain and it takes less time to be metabolized. If smoked, it can produce a high for 8 to 24 hours, whereas smoking cocaine produces a high for approximately 30 minutes. In Colorado, there has been a strong upward trend in smoking methamphetamine. As indicated from treatment admission data, smoking has increased from 12 percent of methamphetamine treatment admissions in 1992 to 63 percent in 2004. From 2000 through 2004, among those admitted to treatment facilities, injecting methamphetamine has decreased from 34 percent of treatment admissions to 21 percent and inhaling the drug has decreased from 21 percent to 12 percent.

From 2000 through 2004, among those admitted to treatment facilities, injecting methamphetamine has decreased from 34 percent to 21 percent and inhaling the drug has decreased from 21 percent to 12 percent.

The methamphetamine user in Colorado

Although there is no typical methamphetamine user, some trends have been reported in Colorado. In its 2006 report on methamphetamine trends, ADAD compared the demographic characteristics of methamphetamine users with other illicit drug and alcohol users.

With the exception of other opiates, females are more likely to receive treatment for methamphetamine in comparison to other substances. From 2000 through 2005, female treatment admissions for methamphetamine have remained fairly stable, between 44 to 50 percent. Researchers suggest that the popularity of methamphetamine use among females may be due to the effects of increased energy and weight loss. With respect to race, methamphetamine treatment admissions in 2005 reflected the distribution of race across the state. But the prevalence of white treatment admissions for methamphetamine decreased from 88 percent in 2000 to 81 percent in 2005 while treatment admissions for Hispanics increased from eight percent to 14 percent during this same time period. Young adults (ages 18 to 25) are more likely to be admitted for methamphetamine treatment than youths (ages 12 to 17) and adults (35 or older). In 2005, the average age of methamphetamine users admitted to treatment was 30, and 31 percent were younger than 25.

Source: *Methamphetamine Trend Analysis, 1992-2004*. March, 2005. Alcohol and Drug Abuse Division, Colorado Department of Human Services. Available at http://www.cdhs.state.co.us/adad/PDFs/MethamphetamineTrendAnalysis.pdf.

Table 7.5. Demographic characteristics of clients admitted to treatment in Colorado, January-December 2005

Characteristics	Alcohol in combination %	Cocaine %	Heroin %	Other opiates %	Marijuana %	Methamphetamine &	(Other) Stimulants* %	All other %
Total (N=24,418)	**9,478**	**2,754**	**1,365**	**682**	**5,196**	**4,645**	**55**	**243**
Gender								
Male	72	59	66	51	76	53	70	63
Female	28	41	34	49	24	47	30	37
Race/ethnicity								
White	67	42	65	86	51	81	67	72
African-American	5	19	8	3	14	1	4	8
Hispanic	23	35	24	9	30	14	29	17
Other	5	3	3	3	5	3	0	3
Age at admission								
17 and younger	5	2	0.4	1	36	4.5	4	9
18 to 24	18	15	13	12	30	27	13	21
25 to 34	25	31	29	30	21	38	38	32
35 to 44	29	35	25	27	10	23	29	22
45 to 54	18	14	24	22	3.5	7	11	11
55 and older	5	2	9	6	0.5	0.4	5	5

Note: *Includes other stimulants (e.g., Ritalin, etc.) and amphetamines (Benzedrine, Dexedrine, Desoxyn, etc.).

Source: Drug/Alcohol Coordinated Data System, CDHS, ADAD.

Why do people involved in the criminal justice system continue abusing drugs?

The answer to this perplexing question spans basic neurobiological, psychological, social, and environmental factors.

The repeated use of addictive drugs eventually changes how the brain functions. Resulting brain changes, which accompany the transition from voluntary to compulsive drug use, affect the brain's natural inhibition and reward centers, causing the addict to use drugs in spite of the adverse health, social, and legal consequences. Craving for drugs may be triggered by contact with the people, places, and things associated with prior drug use, as well as by stress. Forced abstinence without treatment does not cure addiction. Abstinent individuals must still learn how to avoid relapse, including those who have been incarcerated and may have been abstinent for a long period of time.

Potential risk factors for released offenders include pressures from peers and even family members to return to drug use and a criminal lifestyle. Tensions of daily life—violent associates, few opportunities for legitimate employment, lack of safe housing, even the need to comply with correctional supervision conditions—can also create stressful situations that can precipitate a relapse to drug use.

Research on how the brain is affected by drug abuse promises to help us learn much more about the mechanics of drug-induced brain changes and their relationship to addiction. Research also reveals that with effective drug abuse treatment, individuals can overcome persistent drug effects and lead healthy, productive lives.

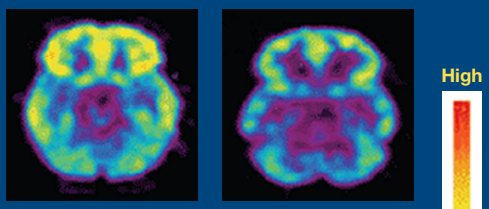
Source: National Institute on Drug Abuse (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations,* U.S. Departments of Health, available at http://www.drugabuse.gov/podat_cj/faqs/faqs2.html.

Is continued drug abuse a voluntary behavior?

The initial decision to take drugs is mostly voluntary. However, when drug abuse takes over, a person's ability to exert self control can become seriously impaired. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decisionmaking, learning and memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction.

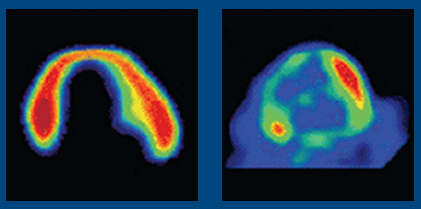
Figure 7.7.

Decreased brain metabolism in a drug abuser



Healthy brain | Diseased brain/ cocaine abuser

Decreased heart metabolism in a heart disease patient



Healthy heart | Diseased heart

Addiction is similar to other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, are preventable, treatable, and if left untreated, can last a lifetime.

Source: From the laboratories of Drs. N. Volkow and H. Schelbert.

Source: National Institute on Drug Abuse (2006). *The Science of Addiction*. U.S. Departments of Health, http://www.drugabuse.gov/scienceofaddiction/addiction.html.

Principles of drug abuse treatment for criminal justice populations

1. Drug addiction is a brain disease that affects behavior.

Drug addiction has well-recognized cognitive, behavioral, and physiological characteristics that contribute to continued use of drugs, despite the harmful consequences. Scientists have also found that chronic drug abuse alters the brain's anatomy and chemistry and that these changes can last for months or years after the individual has stopped using drugs. This transformation may help explain why addicts are at a high risk of relapse to drug abuse even after long periods of abstinence, and why they persist in seeking drugs despite deleterious consequences.

2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time.

Drug addiction is a serious problem that can be treated and managed throughout its course. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence over time. Multiple episodes of treatment may be required. Outcomes for drug abusing offenders in the community can be improved by monitoring drug use and by encouraging continued participation in treatment.

3. Treatment must last long enough to produce stable behavioral changes.

In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more comprehensive services. Early in treatment, the drug abuser begins a therapeutic process of change. In later stages, he or she addresses other problems related to drug abuse and learns how to manage the problem.

4. Assessment is the first step in treatment.

A history of drug or alcohol use may suggest the need to conduct a comprehensive assessment to determine the nature and extent of an individual's drug problems; establish whether problems exist in other areas that may affect recovery; and enable the formulation of an appropriate treatment plan. Personality disorders and other mental health problems are prevalent in offender populations; therefore, comprehensive assessments should include mental health evaluations with treatment planning for these problems.

5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.

Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem solving, skill-building for resisting drug use and criminal behavior, the replacement of drug using and criminal activities with constructive nondrug-using activities, improved problem solving, and lessons for understanding the consequences of one's behavior. Treatment interventions can facilitate the development of healthy interpersonal relationships and improve the participant's ability to interact with family, peers, and others in the community.

6. Drug use during treatment should be carefully monitored.

Individuals trying to recover from drug addiction may experience a relapse, or return, to drug use. Triggers for drug relapse are varied; common ones include mental stress and associations with peers and social situations linked to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention. Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides opportunities to intervene to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying treatment plans according to progress.

7. Treatment should target factors that are associated with criminal behavior.

"Criminal thinking" is a combination of attitudes and beliefs that support a criminal lifestyle and criminal behavior. These can include feeling entitled to have things one's own way; feeling that one's criminal behavior is justified; failing to be responsible for one's actions; and consistently failing to anticipate or appreciate the consequences of one's behavior. This pattern of thinking often contributes to drug use and criminal behavior. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.

8. Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.

The coordination of drug abuse treatment with correctional planning can encourage participation in drug abuse treatment and can help treatment providers incorporate correctional requirements as treatment goals. Treatment providers should collaborate with criminal justice staff to evaluate each individual's treatment plan and ensure that it meets correctional supervision requirements as well as that person's changing needs, which may include housing and childcare; medical, psychiatric, and social support services; and vocational and employment assistance. For offenders with drug abuse problems, planning should incorporate the transition to community-based treatment and links to appropriate postrelease services to improve the success of drug treatment and re-entry. Abstinence requirements may necessitate a rapid clinical response, such as more counseling, targeted intervention, or increased medication, to prevent relapse. Ongoing coordination between treatment providers and courts or parole and probation officers is important in addressing the complex needs of these re-entering individuals.

9. Continuity of care is essential for drug abusers re-entering the community.

Those who complete prison-based treatment and continue with treatment in the community have the best outcomes. Continuing drug abuse treatment helps the recently released offender deal with problems that become relevant only at re-entry, such as learning to handle situations that could lead to relapse; learning how to live drug-free in the community; and developing a drug-free peer support network. Treatment in prison or jail can begin a process of therapeutic change, resulting in reduced drug use and criminal behavior postincarceration. Continuing drug treatment in the community is essential to sustaining these gains.

10. A balance of rewards and sanctions encourages prosocial behavior and treatment participation.

When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective, as can graduated sanctions that are consistent, predictable, and clear responses to noncompliant behavior. Generally, less punitive responses are used for early and less serious noncompliance, with increasingly severe sanctions issuing from continued problem behavior. Rewards and sanctions are most likely to have the desired effect when they are perceived as fair and when they swiftly follow the targeted behavior.

11. Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.

High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems. Personality, cognitive, and other serious mental disorders can be difficult to treat and may disrupt drug treatment. The presence of co-occurring disorders may require an integrated approach that combines drug abuse treatment with psychiatric treatment, including the use of medication. Individuals with either a substance abuse or mental health problem should be assessed for the presence of the other.

12. Medications are an important part of treatment for many drug abusing offenders.

Medicines such as methadone and buprenorphine for heroin addiction have been shown to help normalize brain function, and should be made available to individuals who could benefit from them. Effective use of medications can also be instrumental in enabling people with co-occurring mental health problems to function successfully in society. Behavioral strategies can increase adherence to medication regimens.

13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

The rates of infectious diseases, such as hepatitis, tuberculosis, and HIV/AIDS are higher in drug abusers, incarcerated offenders, and offenders under community supervision than in the general population. Infectious diseases affect not just the offender, but also the criminal justice system and the wider community. Consistent with federal and state laws, drug-involved offenders should be offered testing for infectious diseases and receive counseling on their health status and on how to modify risk behaviors. Probation and parole officers who monitor offenders with serious medical conditions should link them with appropriate healthcare services, encourage compliance with medical treatment, and reestablish their eligibility for public health services (e.g., Medicaid, county health departments) before release from prison or jail.

Source: National Institute on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide (2006).

Preliminary outcomes of domestic violence offenders treated in Colorado

In 2005, 2,744 children received shelter for exposure to domestic violence (DV) in Colorado. According to the Report of the American Psychological Association Presidential Task Force on Violence and the Family (1996), a child's exposure to the father abusing the mother is the strongest risk factor for transmitting violent behavior from one generation to the next. Fifteen years ago the American Medical Association reported that family violence costs the nation from $5 to $10 billion annually in medical expenses, police and court costs, shelters and foster care, sick leave, absenteeism, and non-productivity.[23]

A child's exposure to the father abusing the mother is the strongest risk factor for transmitting violent behavior from one generation to the next.

In 2006, the research committee of the Domestic Violence Offender Management Board (DVOMB), which is administered within the Colorado Division of Criminal Justice, published a study of offenders in court-ordered domestic violence treatment with service providers under the purview of the DVOMB.[24] The research committee was comprised of representatives from the DVOMB, DVOMB-approved treatment providers, community corrections, the Division of Probation Services, victim services, and research staff of the Sex Offender Management Board. The committee developed a data collection form that providers would complete and send to the DVOMB on each offender who was terminated from treatment between September 1, 2004 through April 30, 2006. Over 200 DVOMB-approved providers completed the instrument on more than 5,000 offenders who were discharged from domestic violence treatment.

In 2006, the research committee of the Colorado Domestic Violence Offender Management Board (DVOMB) published a study of offenders in court-ordered domestic violence treatment.

This effort provides a unique snapshot of 5,145 domestic violence offenders who participated in court-ordered treatment in Colorado.

This effort provides a unique snapshot of 5,145 domestic violence offenders who participated in court-ordered treatment in Colorado. Further, analysis of these data allowed for a description of the offenders who successfully completed treatment.

Definitions

Domestic violence. A domestic violence offender in Colorado is defined as "any person who has been convicted of, pled guilty to, or received a deferred judgment or prosecution for any domestic violence offense" (14-11.8-101 C.R.S.). However, if a crime is found by the court to include an act of domestic violence as defined as "an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship" (18-6-800.3(1), C.R.S.), the court may identify the underlying factual basis of the crime as domestic violence.

Treatment. The specialized treatment for domestic violence is assumed to conform to the DVOMB *Standards for the Treatment of Court Ordered Domestic Violence Offenders*.[25] The *Standards* were developed according to best practice as defined by empirical research, and are intended to hold offenders accountable for their actions and treatment providers accountable for the intervention services they deliver. The ultimate goal of the *Standards*, and of treatment, is to increase the safety of victims of domestic violence.

The ultimate goal of treatment and of the Standards for the Treatment of Court Ordered Domestic Violence Offenders, and of treatment, is to increase the safety of victims of domestic violence.

[23] Council on Scientific Affairs, American Medical Association. (1992). Violence against women: relevance for medical practitioners. *JAMA*, 267, 3184-3189.

[24] Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

[25] Published by the Colorado Division of Criminal Justice, and available at http://dcj.state.co.us/odvsom/domestic_violence/DV_Pdfs/Reorganiz.Final%20Edits.4.29.05.pdf.

Characteristics of domestic violence offenders in treatment

The majority of offenders were men (81 percent) and more than 67 percent of offenders were between the ages of 25 and 44. White offenders were disproportionately underrepresented, given that 80 percent of the state population is white: half (56 percent) of the offenders were white, 11 percent were black, 30 percent were Hispanic, and one percent were Asian or Native American.

Two-thirds (68 percent) were employed full-time at the time of offense. Another 10 percent were employed part-time.

The most common crime classification of offenses was misdemeanors (88 percent) and the majority of offenses of record consisted of assault (45 percent), harassment (33 percent), and criminal mischief (8 percent).

Nearly half (42 percent) reported having used a substance (drugs or alcohol) at the time of the offense.

Two-thirds of the group was sentenced to probation. Nearly 800 (797) of the 5,145 of the group were given deferred sentences or diversion status. Two percent of the group was in community corrections halfway houses. A small group (7 percent) received minimal supervision (not actively monitored by a probation officer but required to comply with court ordered conditions).

The majority of offenders (69 percent) reported no prior domestic violence treatment.

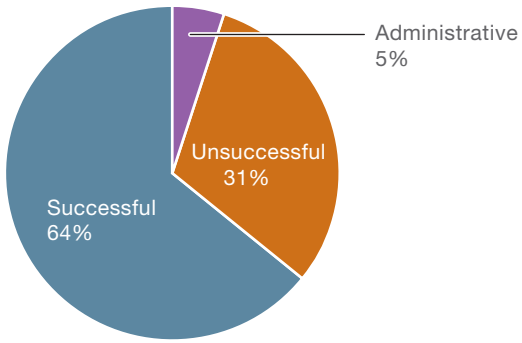
About one-quarter (27 percent) of the group also participated in substance abuse counseling, and seven percent took parenting classes. Seven of the individuals also were in sex offender treatment.

Characteristics of offenders successfully discharged from treatment

Treatment standards require the DVOMB service provider to consult with the responsible criminal justice agency and the victim or victim's advocate/therapist prior to discharging the offender. The collaborative information is used to determine whether the offender is given a successful discharge, an administrative discharge, or an unsuccessful discharge from treatment.

Two-thirds (64 percent) of the offenders in court-ordered treatment successfully completed the program, according to this study.

Figure 7.8. Treatment outcomes of domestic violence offenders



Notes: Administrative discharge (n = 261) is given when the offender is unable to continue in the program because of moving out of state, getting referred to another treatment program, etc.; Unsuccessful (n = 1,552) is given when the offender violates the conditions of the offender contract, and/or violates the terms and conditions of the responsible criminal justice agency; Successful discharge (n = 3,172) is given when the offender completes the treatment program and fulfills the offender contract.

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

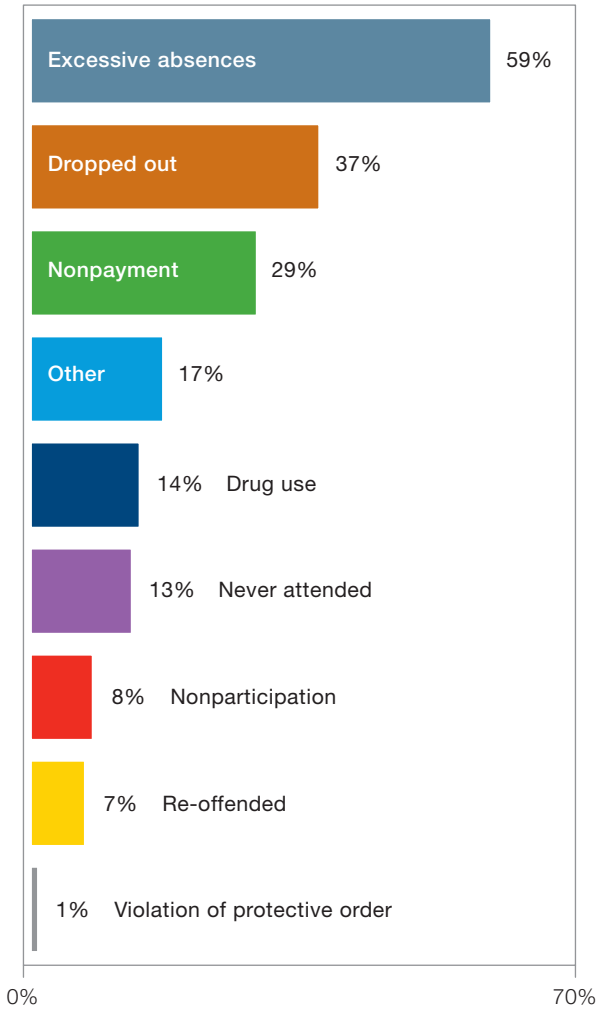
Two percent of the group that entered court-ordered domestic violence treatment reoffended with a known new domestic assault during the time they spent in treatment.

Only seven percent (104) of those who unsuccessfully completed the program were terminated for a new domestic violence crime. This represents 2 percent of the entire group that entered treatment. However, treatment providers may not know about new assaults, particularly among those who rarely or never attend the program.

Over half (59 percent) of those who unsuccessfully completed treatment were terminated for excessive absences, and 29 percent were terminated for lack of payment (note that there could be multiple reasons for each offender). Thirteen

percent of those who failed never attended the program and another eight percent were terminated for lack of participation in the treatment process.

Figure 7.9. Reasons for unsuccessful discharge from domestic violence treatment



Notes: N = 5,145. Offenders could be terminated for multiple reasons.

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

Prior domestic violence treatment participation had no significant impact on the successful outcome of the current treatment.

Additional analyses provided insight into those who unsuccessfully terminated treatment. Offenders who had been in domestic violence treatment before were no more or less likely to complete treatment. This is an interesting finding because, for example, substance abuse studies show that multiple "doses" of treatment seem to have a cumulative effect and tend to improve the outcomes of drug addicts.[26]

Table 7.6. Prior domestic violence treatment did not affect outcome

Prior DV treatment	Successful discharge	Unsuccessful discharge	Total
Yes	472 (61%)	296 (39%)	**768 (100%)**
No	2,385 (71%)	984 (29%)	**3,369 (100%)**

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

Offenders who were employed full-time at the time of the assault were significantly more likely to successfully complete treatment. This finding is consistent with many other criminology studies that show the value of employment in improving program outcomes and reducing recidivism. A larger proportion of those employed part-time failed the program.

Table 7.7. Employment status at crime and successful versus unsuccessful domestic violence treatment discharge

Employment status	Successful discharge	Unsuccessful discharge
Full time*	2328 (73%)	881 (57%)
Part time	262 (8%)	195 (12%)
Unemployed	361 (11%)	377 (24%)
Retired	34 (1%)	4 (<1%)
Public assistance	45 (1%)	24 (1%)
Homemaker	46 (1%)	22 (1%)
Student	52 (1%)	19 (1%)
Other	177 (4%)	72 (4%)
Total	**3128 (100%)**	**1522 (100%)**

Notes: *Includes active military.

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

[26] National Institute on Drug Abuse. (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations a Research-Based Guide*. National Institutes of Health, U.S. Department of Health and Human Services. Washington, D.C. Available at http://www.drugabuse.gov/PODAT/PODATIndex.html.

Domestic violence offenders who were employed full-time at the time of the assault were significantly more likely to successfully complete treatment.

Female offenders were successfully discharged from treatment significantly more frequently than male offenders.

Table 7.8. Domestic violence treatment status by gender

Discharge	Male	Female
Successful	2,499 (63%)	656 (68%)
Administrative	101 (3%)	34 (4%)
Unsuccessful	1361 (34%)	271 (28%)
Total	**3,961 (100%)**	**957 (100%)**

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

Offenders who received minimal supervision were more likely to successfully complete treatment in comparison to offenders who received community supervision and offenders who received community corrections supervision. This is likely due to the fact that those on minimal supervision were considered by probation and judges to be the lowest risk population.

Summary

This study represents a significant step in describing the court-ordered domestic violence offender population and their treatment outcomes. It is also the first time "reoffense" for another domestic assault during the treatment period has been known on a large sample of Colorado offenders. All of these pieces of information have been previously unknown, and the DVOMB project provides critical baseline data for documenting offenders who were court-ordered into domestic violence treatment.

Table 7.9. Domestic violence treatment discharge status

Prior DV treatment	Successful discharge	Unsuccessful discharge	Total
Minimal supervision *	**262 (79%)**	**70 (21%)**	**332 (100%)**
Community supervision	**3160 (67%)**	**1560 (33%)**	**4720 (100%)**
Deferred sentence	599	140	739
Day reporting	25	9	34
Diversion	137	32	169
Home detention	17	5	22
Intensive supervision probation	35	13	48
Parole	21	13	34
Intensive supervision parole	12	14	26
Supervised private probation	784	320	1104
Supervised state probation	1313	845	2158
Denver County probation	74	65	139
Municipal probation	143	104	247
Community corrections supervision	**52 (58%)**	**38 (42%)**	**90 (100%)**
Diversion community corrections	12	5	17
Transition community corrections	17	14	31
Work release **	23	19	42
Other ***	**68 (66%)**	**35 (34%)**	**103 (100%)**

Notes: *Minimal supervision may include supervision by the courts, by district attorneys, or out-of state unsupervised probation. **Work release is a jail sentence and is often used as a condition of regular probation. In many judicial districts, work release is managed by the local community corrections provider through a contract with the local sheriff. ***Other may include such entities as the Department of Social Services, Federal Probation, or the State Hospital.

Source: Domestic Violence Offender Management Board. (2006). *Preliminary report on the findings from the Domestic Violence Offender Management Board Data Collection Project: An analysis of offenders in court-ordered treatment*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

Offenders with mental illness in prison administrative segregation[27]

To combat violence and serious disruptions, prison systems have developed the use of administrative segregation. Nationally, the use of administrative segregation has increased over the years in both state and federal prisons, which has raised concern among many humanitarian groups due to its potential for psychological damage.[28] Many individuals and groups believe that administrative segregation constitutes cruel or unusual punishment as there is often a lack of windows, 24-hour lighting, lack of outdoor exercise, limited contact, denial of reading materials, and/or other meaningful activity.[29]

Administrative segregation, or solitary confinement, is a controlled environment that emphasizes safety and security. It differs from punitive segregation, disciplinary segregation, or segregation, due to the length of stay. The latter are time-limited responses to a disciplinary action after due process and a finding of guilt. Most administrative segregation facilities confine inmates to their cells for 23 hours a day with exercise and personal hygiene restricted for 1 hour, personal contact is kept to a minimum, and visitations are allowed on a limited basis. Release procedures vary, but behavior compliance with institutional rules are typically the conditions under which an offender may be released from administrative segregation.[30]

Court findings of the use of administrative segregation with the mentally ill

The constitutionality of administrative segregation has been challenged several times in the courts. Overall, courts have deemed administrative segregation as unsuitable for inmates with developmental disabilities or mental illnesses. The following court cases have ruled that the use of administrative segregation with offenders with mental illness is a violation of the 8th Amendment regarding cruel and unusual punishment.

Madrid vs. Gomez (1995) *finding: California state officials were in violation of the 8th amendment because the extended housing of mentally ill inmates in administrative segregation exacerbated their current medical condition.*[31]

Ruiz vs. Johnson (1999) *finding: A Texas judge ruled that "extreme deprivations and repressive conditions" of the administrative segregation units were considered cruel and unusual punishment for the mentally ill.*[32]

The constitutionality of administrative segregation has been challenged several times in the courts. Overall, courts have deemed administrative segregation as unsuitable for inmates with developmental disabilities or mental illnesses.

DOC studies the use of administrative segregation in Colorado

Colorado's use of administrative segregation in prison is greater than the national average. In 1998, Colorado Department of Corrections (DOC) reported 5.6% of its prison population was housed in administrative segregation in comparison to the national average of 1.8%.[33] As a result of this finding, the DOC's Office of Planning and Analysis analyzed of the use of administrative segregation in Colorado prisons. The purpose of this study was to examine the characteristics of offenders in administrative segregation.

The Colorado DOC's Office of Planning and Analysis analyzed the use of administrative segregation in Colorado prisons.

The study compared 981 administrative segregation inmates to the overall prison population (16,171), excluding community corrections. Administrative segregation inmates were identified through classification levels on June 30, 2003. This study obtained demographic information, criminal his-

[27] This description has been excerpted from O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

[28] Human Rights Watch (2000). Out of sight: Super-maximum security confinement in the United States. *Human Rights Watch*, 12, 1-9.

[29] Human Rights Watch (2000). Out of sight: Super-maximum security confinement in the United States. *Human Rights Watch*, 12, 1-9.

[30] National Institute of Corrections. (1999). *Supermax prisons: Overview and general considerations*. National Institute of Corrections, Bureau of Prisons, U. S. Department of Justice. Longmont, CO.

[31] Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995).

[32] Ruiz v. Johnson, 37F. Supp. 855 (S.D. Tex. 1999).

[33] O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

tory, psychological assessments, and needs assessment data from information found within the DOC database. Parts of the study are summarized here.

Definition. In Colorado, the definition of offenders with mental illness (OMI) consists of individuals who have been diagnosed with the disorders characterized by perceptual distortions or mood disorders, which require frequent treatment and monitoring. Specifically, the following disorders qualify a classification of OMI: bipolar mood disorder, major depressive disorder, depressive disorder not otherwise specified, dysthymia, paranoid/delusional disorders, schizophrenic disorders, shizophreniform disorder, shizo-affective disorder, psychotic disorder not otherwise specified, induced psychotic disorder, brief reactive psychosis, dissociative identity disorder, post-traumatic stress disorder, and cluster A personality disorders (schizoid, schizotypal, and paranoid).

Prevalence of use of administrative segregation with OMIs

Offenders with mental illness were 1.53 times more likely to be placed in administrative segregation in comparison to offenders without a mental illness. However, being a member of a security threat group (STG) was the strongest predictor of administrative segregation membership. These individuals were 4.5 times more likely to be placed in administrative segregation. Additionally, violent, Hispanic, or single inmates were at greater odds of such a placement than inmates without such characteristics.

Table 7.10. Significant predictors of administrative segregation

Variable	Odds ratio
STG involvement	4.5
Violent offender	2.43
Hispanic	1.91
OMI	1.53
Single	1.47
# of punitive segregations	1.19
LSI-R	1.04
Schizotypal	0.99

Note: N = 17,152. STG means security threat group. LSI-R is the Level of Service Inventory (described in the Recidivism Section) which is a semi-structured interview that assesses criminal risk.

Source: O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

Offenders with mental illness were 1.53 times more likely to be placed in administrative segregation in comparison to offenders without a mental illness.

Offenders with mental illness in administrative segregation also were found to have more serious psychiatric symptoms in comparison to the mentally ill in the general population. These symptoms may create behavior management problems that lead to administrative segregation.

Table 7.11. Axis I diagnosis for mentally ill inmates

Diagnosis	Population	Ad seg
Drug use/dependence	25%	25%
Major depression/ depressive disorders	17%	11%
Bipolar disorders	16%	15%
Dysthymic disorders	11%	13%
Schizophrenia/ psychotic disorders	9%	11%
Anxiety disorders/ptsd/phobias	8%	6%
Alcohol use/dependence	6%	0%
Other disorders	4%	9%
Sexual and gender identity disorders	3%	4%
Disorders usuallly diagnosed in childhood	1%	2%

Note: N = 4,317. Sample size reflects diagnoses rather than inmates, inmates may have multiple diagnoses. Diagnoses are obtained from the American Psychiatric Association Diagnostic and Statistical Manual-IV categories.

Source: O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

Table 7.12. Comparison of the average length of stay in administrative segregation by mental illness status

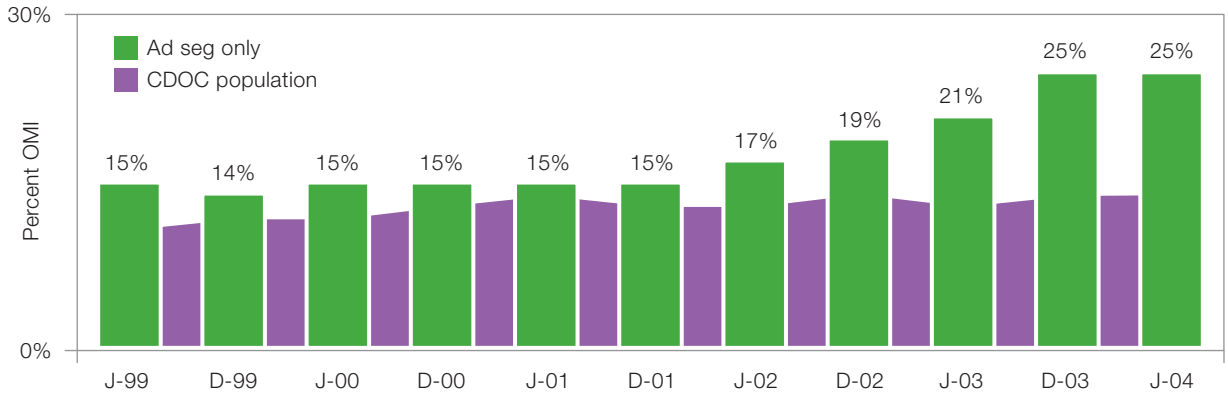
OMI (N=210)	Other (N=137)	No diagnosis (N=634)
16.03 (16.22)	14.00 (13.95)	19.86 (19.86)

Note: N = 981. Median and (standard deviation) are presented.

Source: O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

Researchers at DOC analyzed a 5-year trend of the prevalence of OMIs serving sentences under administrative segregation. The analysis found a significant increase in the proportion of the OMI group serving time in administrative segregation between June 1999 to June 2004. The researchers note that this finding coincides with a dramatic decline in mental health professionals and rehabilitation programs as a result of state budget cuts.

Figure 7.10. Five-year prevalence rates of OMI in administrative segregation



Note: N = 17,152. J = June and D = December/Year.

Source: O'Keefe, M. (2005). *Analysis of Colorado's Administrative Segregation*. Technical Report. Office of Planning and Analysis, Colorado Department of Corrections. Colorado Springs, CO.

The 40 percent increase between FY 2001 and FY 2004 in the proportion of offenders with mental illness serving time in administrative segregation in Colorado prisons coincides with state tax revenue shortfalls and subsequent budget cuts to state agencies.