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BENEFITS OF INTEGRATED DRUG DEMAND-REDUCTION STRATEGY: EFFECTS OF TREATMENT FUNDING ON PUBLIC HEALTH AND PUBLIC SAFETY IN BALTIMORE

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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BENEFITS OF INTEGRATED DRUG DEMAND-REDUCTION STRATEGY: EFFECTS OF TREATMENT FUNDING ON PUBLIC HEALTH AND PUBLIC SAFETY IN BALTIMORE

TUESDAY, MARCH 5, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Baltimore, MD.

The subcommittee met, pursuant to notice, at 10:02 a.m., in War Memorial Building, 101 North Gay Street, Baltimore, MD, Hon. Mark E. Souder (chairman of the subcommittee) presiding.

Present: Representatives Souder and Cummings.

Also present: Christopher Donesa, staff director and chief counsel; Nicholas P. Coleman, professional staff member and counsel; and Conn Carroll, clerk.

Mr. SOUDER. The subcommittee will come to order. Good morning and thank you for coming.

It is a great pleasure to be here in Baltimore today at the invitation of our Ranking Member Congressman Cummings and to be joined by Lt. Governor Townsend, Mayor O'Malley and so many other leaders to discuss the successes of drug treatment programs in Baltimore.

Drug treatment is possibly the most essential component of an integrated national drug strategy. The events of last year prevented us from spending as much of the subcommittee's time as we would have liked on drug treatment issues, so I welcome the opportunity presented today to return to and accelerate the discussion. Two of the three main goals set forth in the National Drug Control Strategy recently announced by President Bush and Director Walters are related to prevention and treatment: "Stopping Use Before It Starts" through education and community action, and "Helping America's Drug Users" by getting treatment resources where they are needed.

As part of the second goal, both the administration and the subcommittee will be seeking better information about fundamental questions: what works in drug treatment, why it works, and where there are shortages of capacity. We are looking at significant increased in budget support for the Substance Abuse and Mental Health Services Administration [SAMHSA], but the Government cannot invest those funds wisely until we know how best to provide those services. The Office of National Drug Control Policy is redou-

bling its efforts to address those fundamental questions, and we look forward to working with them.

One thing we do know is that effective drug treatment programs can make a meaningful difference. Drug treatment can reduce use of both hard drugs and marijuana, illegal behavior by addicts and improvement in employment status. The Drug Abuse Treatment Outcome Study found that, nationally, use of the primary drug of choice by addicts dropped 48 percent and that the number of health visits related to substance abuse declined by more than 50 percent. Five years after treatment there was a 21 percent reduction in the use of illegal drugs. While these statistics and successes do not themselves hold the key to all treatment issues, we must for example, also find out how to encourage addicts to enter and stay in treatment, as well as how to make it more available. They speak to the plain fact that a good treatment program can clearly have an impact on the lives, health and future of individual users and their families.

[The prepared statement of Hon. Mark E. Souder follows:]

Opening Statement
Chairman Mark Souder

"Benefits of an Integrated Drug Demand-Reduction Strategy: Effects of Treatment Funding on Public Health and Public Safety in Baltimore"

Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Committee on Government Reform

March 5, 2002

Good morning and thank you for coming. It is a great pleasure to be in Baltimore today at the invitation of our Ranking Member Congressman Cummings and to be joined by Lt. Governor Townsend, Mayor O'Malley and so many other leaders to discuss the successes of drug treatment programs in Baltimore.

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Today we are in Baltimore to hear about the findings of the "Steps to Success" drug and alcohol treatment outcomes study, reviewing the many successes of treatment programs in Baltimore. We will be joined on our first panel by Baltimore Mayor Martin O'Malley, Lt. Governor Kathleen Kennedy Townsend, and Police Commissioner Edwin Norris. On our second panel, we will hear testimony from Ms. Renee Robinson, Treatment and Criminal Justice Program Manager for the Washington/Baltimore HIDTA, and Judge Jamey Weitzman from the Baltimore City Drug Treatment Court. On our third panel, we will focus directly on the "Steps to Success" report, with Dr. Peter Beilenson, Baltimore City Health Commissioner, Dr. Jeannette Johnson of SUNY-Buffalo, Mr. John Hickey of the Tuerk House Drug Treatment Center, and Elizabeth Seward, a graduate of the Tuerk House program. Thanks to all of you for coming, and to Congressman Cummings and his staff for organizing the excellent panels of witnesses today. I look forward to your testimony.

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Now I would like to recognize Mr. Cummings for his opening statement.

STATEMENT OF HON. ELIJAH E. CUMMINGS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. CUMMINGS. Mr. Chairman, I want to thank you for agreeing to my request for today's field hearing of the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources. I truly appreciate both your willingness to come to Baltimore City, and your sincere interest in the issue of drug treatment.

I also want to thank all of our witnesses for being here to share their diversion of individual perspectives toward Baltimore's progress in providing effective drug treatment. I might add that when the subcommittee came here before in which Chairman Mica was then the chairman, it was no doubt that it did have some effect, because of the fact that we saw a greater attention after that given to drug treatment. And I am sure with your commitment to treatment we will see similar benefits from today's hearing.

As we all now, America's war on drugs has generated another equally intense war of conflicting opinions. While there is consensus around the premise that the problem of illegal drug consumption inflicts enormous harm on America and society, there also has been a sharp disagreement as to how to go about eradicating it. As is the case in most public disputes, the issue boils down to how to allocate finite resources. We can all agree that we must do something about stopping the flow of drugs into the United States from abroad, that we must enforce the law, that we must provide treatment, that we must try to prevent and discourage drug use, and so on. But in what order?

Budgetary realities dictate that we must make choices. Every expenditure, therefore, must be justified in terms of benefits to the public that it supports. In the minds of some policymakers, the extent to which we can establish that treatment actually works is central to the debate over increasing Federal funding. We have heard that over and over again now in Washington where the question has raised, does treatment work and how do we make sure

that it does work. And I noticed in the Lt. Governor's testimony, she talks about that. I look forward to hearing your testimony.

While there has been ample research on the subject of drug treatment outcomes, large differences in methodology focus, scope and rigor of the studies make evaluating the accuracy of the data very difficult. A March 1998 report by the U.S. General Accounting Office surveyed the available research on drug treatment outcomes in order to determine the effectiveness of Federal drug treatment funding. The report concluded that, "While studies conducted over nearly three decades consistently show that treatment reduces drug use and crime, current data collection techniques do not allow accurate measurement of the extent to which treatment reduces the use of illicit drugs." Now that report was from 1998.

Opponents of increased funding cite the lack of definitive proof of treatment effectiveness as justification for their position. At the same time, the proponents of making drug treatment available on demand stress the abundance of data that shows that drug treatment is in fact beneficial. The opponents of increased treatment funding have tended to focus upon the absolute abstinence as a measure of treatment effectiveness. Meanwhile, proponents of the expanded heed the advice of the institute of medicine. The institute has found that, "An extended abstinence, even if punctuated by slips and short relapses, is beneficial in an of itself, and may serve as a critical intermediate step toward lifetime abstinence and recovery."

In the context of this debate I welcome the fact that policymakers within Congress and the administration are now seeking to identify a common ground on this important issue. We may be seeing the emergence of a new pragmatic consensus that recognizes the need for effective treatment, programs and good law enforcement practices to function as two complimentary arms of the same successful strategy. In this environment, the need for new and better research on treatment effectiveness cannot be more clear.

The recently completed Baltimore Drug and Alcohol Treatment Outcome Study, "Steps to Success" comes at an opportune time. As we will hear from those who commissioned "Steps to Success", those who conducted the research and those who cooperated, the study is the largest and most rigorously conducted scientific study of drug treatment outcomes to focus on a single city. There is none like it in this country. The unequivocal conclusion is that treatment does work to reduce drug and alcohol abuse. And treatment also reduces the range of other maladies that flow from drug use, including drug related crime, overdose deaths, emergency room presentments, risky health behaviors and depression.

Mr. Chairman, Baltimore City's devastating drug problem has become well known to the Nation. For the benefit of communities around the country that are similarly besieged by drug abuse, it is very, very important that Baltimore's recent progress of addressing the drug plague and the challenges that remain to be overcome should also be well known. That I think is the main reason why we are here today. For the benefit of individuals, families and communities throughout the United States, we need to carefully consider what Baltimore has learned from its experience with expanded drug treatment funds.

I again thank the chairman. I want to thank all of the staff of the—the chairman's staff and all of my staff, and every—and the committee's staff that took time to pull all this together. I really appreciate it. It took a phenomenal amount of work to take the hearing out of Washington and bring it to any locale, just puts a tremendous burden on the staff. And I want to thank all of you for your cooperation and your hard work. With that, Mr. Chairman, I look forward to hearing from our witnesses.

Mr. SOUDER. Thank you very much. And, hopefully, today will help us. We have had difficulty moving Congressman Ramstad's bill on insurance to make sure that insurance companies will help provide the coverage for drug and alcohol treatment. Because so many times people lose their coverage and get kicked out of a program because their moneys run out. And that has been one of our long-standing problems.

I also want to say, it is good to be back in Baltimore. In my earlier lives when I was public and staff director on the Children Family Committee, we visited the Johns Hopkins in the mid-80's who was a pioneer in dealing with crack babies, trying to identify family problems there. I have been up in Sandtown looking at the Community Health Center there years ago as well in that work. Because as we realize, and then when I chaired the Empowerment Subcommittee that was created when the republicans first took over Congress, we had Mr. Mafumy, your predecessor, in to talk about some of the economic development things that need to be done. Because a lot of these problems are interrelated. And we all realize that. Baltimore has been a creative center. We also worked with, when I was with the Children Family Committee with one of the distinguished Lieutenant Governors relatives, Eunice Schriver, on a number of problems, teen pregnancy. And your family has been very active. And we appreciate you coming today.

First, let me take care of a couple of procedural matters. I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record. Then the answers to written questions provided by the witnesses also be included in the record. Without objection, it is so ordered.

Second, I ask unanimous consent that all exhibits, documents and other materials referred to by Members and the witnesses may be included in the hearing record. And that all Members may be permitted to revise and extend their remarks. Without objection it is so ordered.

Since this is an oversight committee, it is our standard practice to ask all of our witnesses to testify under oath. So if you would rise and swear the other witnesses in as they come.

[Witness sworn.]

Mr. SOUDER. Thank you very much. Let the record show that the witness has answered in the affirmative.

It is our honor today to have the distinguished Lt. Governor Kathleen Kennedy Townsend here. We appreciate you coming, and you are recognized for 5 minutes.

STATEMENT OF KATHLEEN KENNEDY TOWNSEND, LT. GOVERNOR OF MARYLAND

Ms. KENNEDY TOWNSEND. Thank you very much, Chairman Souder. And thank you for your kind words that you have said about our city and our creativity. We really appreciate it. It is great to be here with Congressman Cummings who has been a leader in making our community safer. And has been a real partner in our state's effort to make sure that we are doing all we can to help our communities and to help our families and our citizens in this city. Thank you, Congressman Cummings.

As Lieutenant Governor, I have been in the unique position to direct Maryland's substance abuse and law enforcement efforts over the last 7½ years. In fact, I chair Maryland's Drug and Alcohol Council. And we made recommendations 2 years ago that we should increase the amount that is spent on drug treatment by $300 million over the next 10 years. I was glad to hear you say that part of that should come from private insurance. Our council said that $200 million should come from the state funds. But that $100 million should come from private insurers who, as you pointed out, very well often do not want to fund drug treatment or mental health treatment. So I wish you the best, I wish you luck in making sure the law passes as you have described it.

I also oversee as Lieutenant Governor the Departments of Public Safety and Corrections, Juvenile Justice, and the Maryland State Police. I am chair of the Cabinet Council on Criminal and Juvenile Justice. With help from many partners throughout the state, state agencies, local jurisdictions, research based programs, we have steered Maryland toward dramatic reductions in crime. In fact, the lowest reductions in a generation. This would not have happened without our integrated approach of effective treatment and smart policing. What we have achieved has not been easy. But with leadership and vision, and I have to tell you, help from the Federal Government, we have found the right road. And the Federal Government has been an essential partner in all that we are doing in Maryland and in Baltimore City. And we are very, very grateful that you have come here to listen to what we have done. And I hope to help us in the coming session.

Let me just take a few minutes to frame this issue in a broad view. Let me say, and I think this is what Congressman Cummings said and Congressman Souder as well, for a long time we were stuck in a fruitless debate about false choices. Should we spend more money on treatment, or should we spend more money on enforcement. After a long time of self-doubt, we also we were wondering if this treatment work, do prosecutors, probation officers, police actually make a difference. So there was always a question, what is effective, what will really help communities, what will help citizens.

I would say that in Maryland we have learned some important lessons over these last few years. And I would like to welcome this opportunity to tell you what we have learned. One, we have learned that effective law enforcement with smart policing, involving parole and probation officers and prosecutors, works. That drug treatment works. And that getting communities involved to improve the quality of our lives works. We can improve the quality

of life in our communities. We can provide and must provide both effective law enforcement and effective drug treatment.

We have invested in fighting crime in these ways and we have seen consistent reductions in crime. It has been a partnership of the Federal Government, state government, local government, and countless citizens who simply refused to give up.

Let me just touch briefly on what we have done at the state level. The State has invested in law enforcement in Baltimore City. In the past 2 years, for example, we have doubled the capacity of the State's Attorney's Office to prosecute the violet gun crimes. The result, more convictions of violet felons who terrorize our streets. We have provided millions of dollars to support policing in Baltimore City. And the results, better trained police force, better equipment to investigate crimes and track down criminals. We have supported community strategies in 12 hot spot communities in Baltimore that account for almost a third of the city's violent crime. And the result, we have had a 40 percent reduction in violent crime in our city's most challenged neighborhood.

We have also begun to invest fundamentally in how offenders are supervised. Particularly, drug addicted offenders. When I first became Lieutenant Governor, an average parole probation officer would have enough money to do seven drug tests per month for a case load of over 100 offenders. That is seven per month for a case load of over 100 offenders. Obviously, they had no idea who was doing drugs, how often they were doing drugs, and what drugs they were doing. And this is a time that we knew from national research that over between 50 and 60 percent of all the cocaine and heroin used in the United States are used by people on parole or probation. In other words, the very people that were under our supervision were those that were fueling the drug trade. And this did not make any sense at all. And so we decided to change it.

In 1996 under Judge Weitzman's leadership we started a Drug Court. And in 1999 building on the lessons of the Drug Court we began to implement Break the Cycle, Maryland's path-breaking effort to change behavior of people on parole and probation. This combines a regular drug test with treatment and the scheduled sanctions. Today over 11,000 offenders are under community supervision. Drug use has dropped by more than half in the first 4 months among offenders who are being tested twice a week. And recidivism dropped by 29 percent among the sample on Baltimore City. In other words, it worked.

In the last few years the State of Maryland has doubled the amount of money that we are spending in drug treatment in Baltimore City. We have invested another $16 million. And this year in this year's budget, we are asking for another $13 million, which may not sound like a lot to Congressman, but for our state it is substantial. And $9 million to go to Baltimore City. We are working to make sure we get that budget funded. And I know you have been very helpful, and as well, Commissioner Norris. And I want to thank you for it.

But let me just tell you about the results in the last 2 years. Emergency room admissions are down, overdose deaths are down, crime is down, and behavior that spreads the deadly AIDS virus is down. Let me just say, it works, it is effective, it can be done well.

But I am not just talking rhetoric. We have also launched first in the state, first state to do effectiveness evaluation. We are working with John Carnavali, who used to be at HIDTA, to ask him to work throughout the state to see which kind of treatment works for which kind of offender, or which kind of drug abuser so that we are not just talking about how many slots we have. We are talking about what slot, what is needed for which kind of person. And I am telling you it has been effective, it works. And the good thing about it is that as we work with treatment programs throughout the state, each one is saying, we want to work with you. We want to know what works. We want to be here to help people get off of drugs. We do not just want to receive more dollars. We want to make sure those dollars are used well.

I thank you so much that you have come and heard this this morning. You will soon hear from the mayor and the commissioner of police who I think share that same message. Drug treatment works. You need smart law enforcement. And you treat drug treatment and you can really make a difference. Thank you very much.

[The prepared statement of Ms. Townsend follows:]

Written Testimony of Lt. Governor Kathleen Kennedy Townsend

HOUSE COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES
BALTIMORE CITY CONGRESSIONAL FIELD HEARING:

"Benefits of an Integrated Demand-Reduction Strategy: Effects of Treatment Funding on Public Health and Public Safety in Baltimore."
March 5, 2002: 10:00 a.m. – War Memorial Building, First Floor
Fayette and Gay Streets, Baltimore

Good Morning Chairman Souder and Congressman Cummings. Chairman, it is wonderful to have you in Baltimore, Maryland to talk about how we are making our communities safer. And, it is wonderful to be with Congressman Cummings once again. The Congressman is a tireless champion for the people of this state and of this city. The federal government is an essential partner to all that we are trying to do in Maryland, and in Baltimore City. We are grateful that you have come today to hear about our many experiences and our vision for the future.

To broadly frame this discussion, let me say that for a long time in our country, we were stuck in a fruitless debate about false choices. Either we needed stronger law enforcement or we needed more treatment. And for a long time, we were stuck in self-doubt about our ability to really make a difference in our communities. Could police, prosecutors, and probation officers make a difference? Could drug treatment really be effective?

As Lt. Governor, I have been in a unique position to direct Maryland's substance abuse and law enforcement efforts over the last eight years. I created and continue to chair the state's Cabinet Council on Criminal and Juvenile Justice. I chair the state's Drug and Alcohol Council and I oversee the departments of Public Safety and Corrections, Juvenile Justice, and the Maryland State Police. With the help of my many partners throughout Maryland - in the state agencies, in local jurisdictions, in our many research-based treatment programs – collectively we have steered our State to dramatic reductions in crime due in part to our integrated approach to effective drug treatment and smart policing. It has not always been easy, but with leadership and vision, we have found a strong path.

In Maryland, we have learned some important lessons over these years –and we welcome the opportunity to share them with you. We have learned that: smart law enforcement coupled with effective parole and probation and prosecution works; drug treatment works and getting communities involved to improve the quality of life works. We can improve the quality of life in our communities. We can provide – and we must provide -- both effective law enforcement and effective drug treatment.

We have invested in fighting crime in these ways and we have seen consistent reductions in crime. Overall crime in Maryland is at it lowest point in over 25 years. It has been a partnership of the federal government, of state government, of local government, and of countless citizens who refuse to give up.

Allow me to touch briefly on some of the ways in which our State has invested in this effort. The State of Maryland has invested in law enforcement in Baltimore City and it has shown results. In the past two years, we doubled the capacity of the state's attorney's office to prosecute violent gun crime –the result, more convictions of violent felons who terrorize our streets. We have provided millions of dollars to support policing in Baltimore City. The result is a better-trained police force with better equipment to investigate crimes and track down criminals. We have supported community strategies in 12 HotSpot communities in Baltimore that account for almost a third of the city's violent crime. The result is a reduction of more than 40% in serious crime in some of the City's most challenged neighborhoods.

We have also fundamentally changed how offenders are supervised, especially drug addicted offenders. Until a few years ago, probation officers had only 7 drug tests to randomly apply to their caseload of often more than 100 people. In other words, they had no idea at all whether offenders under supervision were using drugs. Meanwhile, we knew from national research that people who are on parole or probation consume more than half of the cocaine and heroin consumed in the United States. In other words, individuals already under the supervision of the criminal justice system were fueling the drug trade. This clearly did not make sense.

So in 1996, we began the Drug Court in Baltimore City, thanks to the hard work of Judge Weitzman who you will be hearing from later. And in 1999, building on the lessons of Drug Court, we began to implement Break the Cycle, Maryland's path breaking effort to change the drug using behavior of people on parole or probation. Break the Cycle combines regular drug tests with

treatment, and a schedule of sanctions to push offenders to stay in treatment and hold them accountable if they fall off the wagon.

Today, over 11,000 offenders under community supervision are supervised in this way. The results, even after just a few years, are encouraging. Drug use dropped by more than half in just four months among offenders being tested twice a week. And recidivism dropped by 29% among a sample in Baltimore City.

Mr. Chairman, the Break the Cycle initiative highlights how essential the link between drugs and crime is, and how equally important is the link between law enforcement and drug treatment.

Maryland has invested heavily in Drug Treatment, and it has shown equally encouraging results. In the last two years alone, Maryland has doubled funding for drug treatment. In Baltimore City, we have invested an additional $16m during the past two years. This year, the Administration's budget requests an additional $13m in new funding for the State, including an additional $9m to Baltimore City. The Mayor and I are working together now to make sure that this funding is preserved as the General Assembly deliberates the budget. I urge everyone in this room to make clear to your legislators that we cannot go backwards, and we cannot stand still in our support for drug treatment. We must move forwards.

And Maryland's historic investment in Drug Treatment is producing historic results: emergency room admissions are down; overdose deaths are down; crime is down; and behavior that spreads deadly AIDS virus is down.

Let me also emphasize that this investment of dollars has been accompanied by an equal emphasis on effectiveness. To improve the effectiveness of drug treatment services the State has developed a system of accountability measures that are now being piloted. These will help us make sure that our treatment programs are doing as much as they can to free people from the grip of addiction. Because we all know that addiction is far more than statistics, and treatment is far more than the "number of slots".

We have, all of us, been personally touched by the waste, the tragedy of addiction. By the hole it leaves in families, and in communities. But we have also, been touched by the energy and hope of recovery. The result of effective treatment is not just that less bad things occur. It is that families are reunited,

lives are healed, and souls are restored. The ripple effects from every successful recovery are one of our greatest resources to rebuild our communities.

Likewise, the result of effective law enforcement is not just that more criminals get caught. It is that parents can let their children out front to play, that senior citizens can sit on the front porch and enjoy the breeze on a summer evening. In short, it means that people can live as they should without the constant fear that crime may shatter their lives.

In closing, let me thank you all for coming here today. As you have heard, in Maryland and in Baltimore, we have invested in law enforcement and in treatment and in our communities. And it is working. The federal government has been a crucial partner in the past and we know that it will be in the future. Thank you for your interest and your commitment.

STATE OF MARYLAND

DRUG AND ALCOHOL COUNCIL

Drug and Alcohol Treatment Adds Value:
It is Cost-Effective and Saves Maryland Taxpayers Money

Research has shown:

Drug treatment reduces crime:

According to an analysis of the federal National Treatment Improvement Evaluation Study (NTIES) data, one year after treatment:

- The average number of crimes committed per year **dropped by 74%.**
- Physical beatings and related violent crimes **dropped by 78%.**
- Crime-related costs to the tax-paying population **fell by 75%.**

Drug treatment decreases welfare dependence:

- Welfare dependence **decreased by 11%** among 4,400 individuals one year after substance abuse treatment was completed. (NTIES)
- Individuals who complete treatment **reduce their involvement** with the child welfare system by **50%.** (General Accounting Office, 1998)

Drug treatment reduces health care costs:

According to an analysis of the NTIES data, one year after treatment:

- Average total health care costs per client per year **declined by 11%.**
- Hospital and emergency room encounters declined, saving **$1.45 million.**

Pregnant women receiving drug treatment produced a mean **net savings of $4,644** per mother/infant pair at the John's Hopkins Center for Addiction and Pregnancy.

Drug treatment increases employment and wages:

According to an analysis of the NTIES data, one year after treatment:

- Employment **increased by 19%.**
- Average earnings **increased by 9%.**
- The average annual taxes paid per client **increased by 6%.**

The National Institute on Drug Abuse estimates that every $1 spent on treatment saves $7: $4 in reduced public costs and $3 in increased productivity.

According to the CALDATA study, treatment saved taxpayers approximately $8,000 per participant in health, welfare and criminal justice costs.

The cost of each day of treatment is paid for, on the day it is provided, by benefits that exceed the cost.

For more information about the Maryland Drug and Alcohol Council contact Thomas Davis at 410.321.3521.

Mr. SOUDER. Thank you. As I said earlier, as an oversight committee we swear in our witnesses. So therein, police commissioner, if you could rise and take the oath.

[Witness sworn.]

Mr. SOUDER. Let the record show that both witnesses answered in the affirmative. And we appreciate you coming today. Mayor O'Malley, would you like to give your testimony next?

STATEMENT OF MARTIN O'MALLEY, MAYOR, CITY OF BALTIMORE

Mr. O'MALLEY. Sure. Absolutely. And I appreciate your coming. My trip was a lot shorter than yours, I suspect. Mr. Chairman, members of the committee, I want to welcome you, first of all, to the greatest city in America. And I appreciate the opportunity to speak with you about some of the success we have been having here in Baltimore, which would not have been possible without Federal help. On both sides of the political aisle, across the United States, I think there is a growing consensus that effective drug treatment has to be part of any serious effort to reduce crime. You cannot talk about criminal justice, you cannot talk about safer streets without also talking about, and more importantly, without funding drug treatment.

For years many of us were engaged in this pointless debate pitting law enforcement dollars against drug treatment dollars. And what we have proven here over the last couple of years in Baltimore is that we can move past that debate, we can do more of both. And we can do it in a way that makes our streets a much safer place. We have done that in Baltimore.

One, just 2 years ago Baltimore was No. 1 among major cities in terms of drug, in terms of violent crime. No. 1 in terms of drug addiction. I am glad to report now that over these last 2 years Baltimore has been No. 1 among major cities in the reduction of violent crime. A double-digit, back-to-back reductions of about 21 or 23 percent. Baltimore was No. 1 among major cities in reducing drug related emergency room admissions, according to the Federal Government Health and Human Services report, down by 19 percent. One of only two cities that was actually going down. The one that followed us was San Francisco, which had about a 12 percent reduction.

And by making progress on both of these fronts, we have dramatically reduced the number of citizens in our city who have died from drug related deaths, whether it is from homicides or overdoses. If you combine the murders and the overdoses in 1999, 628 of our fellow citizens died from overdoses and murders combined. Last year that number was 502. Still 502 too many, but 126 lives saved in two short years of working hard on this problem.

This progress has required significant investments. It has required an unprecedented partnership between Baltimore City, the State of Maryland, and our Federal Government. Congressman Cummings, I want to thank you and your colleagues for your leadership you have shown, and that investment in Baltimore's turnaround.

On the law enforcement front city government has been the lead investor, as well we should be, increasing city spending by $32 mil-

lion in 2 years. And this investment has been supplemented by a $9 million COPS grant.

On the drug treatment front, the State of Maryland, under Governor Glendening/Townsend administration, has been the lead investor in increasing its level of treatment by funding by $16 million with a promise of an additional $9 million. I have my finger crossed because Legislature is in session.

The rise in state treatment funds since 2000 has been accompanied by an increase in local, private and Federal funding from $11 million to $14 million over that same time period. Just last month Hopkins and the University of Maryland and Morgan State issued a report on the effectiveness of drug treatment, noting that after 1 year in Baltimore City, heroin use dropped 69 percent among those that were in treatment, cocaine use dropped 48 percent, criminal activity dropped 64 percent. We have also become very much a performance driven organization as local government. We track a lot of, and each of our departments through CityStat or the police department through Comstat. CityStat, by the way, is just an expanded use of Comstat. We deploy our resources to where the problems are. We measure for results. And programs have shown that they are getting results get the increased funding.

We do this now with regard to drug treatment programs. Dr. Beilenson joining us here, our health commissioner, who chairs DrugStat where we measure retention rates, recidivism, all sorts of indicators as to whether or not a person is actually moving out of that self-destructive cycle of drug addiction.

Two weeks ago John Walters, Director of the Office of National Drug Policy, came to Baltimore to talk about national goals that for the very first time targets specific reductions in drug use. Ten percent in 2 years and 25 percent in 5 years. Director Walters was very familiar with our efforts here. And we intend to do our share to meet that national goal. And I think it was encouraging to him to see a city like ours turning things around and making those sorts of dramatic strides. The citizens of our city and state have benefited greatly from this partnership. We move beyond the zero sum debate.

With your leadership, the people of our Nation can benefit from a similar approach. We cannot arrest our way out of this drug problem. We cannot only treat our way out of this crime problem. We have to do both. We have to disrupt the supply by jailing dealers and reduce demand by showing their customers a better way to live.

And I thank you all very much for your leadership and for hearing me out.

[The prepared statement Mr. O'Malley follows:]

MARTIN O'MALLEY
Mayor
250 City Hall
Baltimore, Maryland 21202

March 5, 2002

Testimony of Baltimore Mayor Martin O'Malley

Subcommittee On Criminal Justice, Drug Policy & Human Resources

House Committee On Government Reform

Mr. Chairman, Congressman Cummings, Members of the Subcommittee. Thank you for the opportunity to join you today. This hearing represents a very positive trend in our nation: On both sides of the political aisle, across the United States, there is a growing consensus that effective drug treatment must be part of any serious effort to reduce crime.

For years, elected leaders engaged in a pointless debate pitting law enforcement against drug treatment as an either/or proposition. Baltimore – a city that was caught up in this stale debate for years – today, is the first city to move past it.

By pairing effective law enforcement strategies, which have been proven in other cities, with the nation's most effective drug treatment program, we are achieving best-in-the-nation results:

- Baltimore was #1 among major cities over the last two years in reducing violent crime – down by 23%.
- Baltimore was #1 among major cities in reducing drug-related emergency room admissions, according to the most recent U.S. Department of Health and Human Services report – down by 19%.
- And by making progress on both of these fronts, we have dramatically reduced the number of Baltimore's citizens who die drug-related deaths from violence and overdoses – down from 628 (305 murders, 323 overdoses) in 1999 to 502 (259 murders, 243 overdoses) in 2001. This represents Baltimore's lowest murder total since the 1980s, and the lowest overdose total since records have been kept.

This progress has required a significant investment. And it has required an unprecedented partnership between Baltimore City, the State of Maryland and the federal government. Congressman Cummings, I would like to thank you and your colleagues for the leadership you have shown – and for your investment – in Baltimore's turnaround.

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On the law enforcement front, city government has been the lead investor, increasing city spending by $32 million in two years. This investment has been supplemented by a $9 million increase in federal funding – primarily a COPS grant to hire additional police officers – with State funding remaining flat. It also has been complimented by an unprecedented increase in drug treatment funding.

On the drug treatment front, the State, under Governor Glendening's leadership, has been the lead investor, increasing its level of treatment funding by $16 million – with the promise of an additional $9 million increase next year, for a total of $25 million.

The rise in State treatment funds since FY 2000 has been accompanied by an increase local, private and federal funding from $11 million to $14 million. And just as the increased investment in drug treatment complements our law enforcement efforts, our joint drug treatment efforts benefit from better law enforcement – which was previously underfunded.

Additional resources, however, must be accompanied by strict accountability. When public dollars are invested, citizens have a right to see what they are getting for their money.

Just last month, Johns Hopkins University, the University of Maryland and Morgan State University issued a report on the effectiveness of our drug treatment efforts – noting that, after one year, heroin use dropped 69%, cocaine use dropped 48% and criminal activity dropped 64% among individuals in treatment.

We also have adapted Comstat – the management accountability initiative successful in driving down crime in New York City and here in Baltimore – to maximize the effectiveness of our drug treatment funds. Through DrugStat, we are tracking: how many people are in treatment in Baltimore; how long they stay with their program; how many patients test positive for drugs while in treatment; how many people leave treatment with a job; and how many are arrested after treatment. By holding treatment facilities accountable – we reduce or eliminate funding for programs that don't measure up – and by sharing information, we are improving results.

This trend to measure outcomes – not just the funding that goes in – also is appearing on the national level. Two weeks ago, John Walters, Director of the Office of National Drug Policy, came to Baltimore to talk about national goals that, for the first time, target specific reductions in drug use – 10% in 2 years and 25% in five years. Director Walters was very familiar with our efforts here, and we intend to do our share to meet that national goal.

Our progress in drug treatment, combined with better law enforcement, is reflected in our continuing progress in reducing our unacceptable level of violence. Although, it is early in the year, we have reduced crime 41% compared to the same time period in 1999. And murders are down 16% from last year – which represented our lowest total since the 1980s.

The citizens of our city and State have benefited greatly from our partnership to tackle the twin ills of crime and addiction. Lives are being saved, and we are making progress in turning around problems that were long thought to be intractable.

With your leadership, the people of our nation can benefit from a similar approach. We can't arrest our way out of a drug problem. And we can't treat our way out of a crime problem. We must disrupt supply by jailing dealers, and reduce demand by showing their customers a better way to live.

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Mr. SOUDER. Thank you for your testimony. Commissioner Norris.

STATEMENT OF EDWARD T. NORRIS, COMMISSIONER, BALTIMORE CITY POLICE DEPARTMENT

Mr. NORRIS. Gentlemen, I want to thank Congressman Cummings and everyone else for this opportunity, because this is extremely important to the police department. One thing that both the Lieutenant Governor and the mayor touched on was the fact that in the past this was mostly mutually exclusive. People thought that the police chiefs would not be in support of drug treatment and we have a different goal or agenda. And nothing could be further from the truth. Because the fact is what we have been saying since we got here was you cannot arrest your way out of this problem. You don't arrest your way out of a crime problem bringing a city back to where it needs to be. We have been saying for several years.

When I got here, you know, I got my initial brief on the standard of the city. And the picture was not very bright. And we were No. 1 in every crime category in America at the per-capita rate. And the DEA came in and they spoke to me. And my briefing was even more chilling. We were No. 1 in emergency room admissions for both heroin and crack cocaine. Not good.

In 2 years this has come down and come down dramatically. We may have one of the sharpest declines in America, if not the sharpest crime decline in the last 2 years in violent crime, which did not happen by accident. And did not happen by police intervention. But we are a much more effective police department, I believe. We are doing a better job at what we do, and that is you know, our deployment, our investigations. We are a real police agency again. And we are very proud of that.

But the fact is, is the hard work of all the people in this room, from Annapolis, from the Mayor's Office, the health commissioner, and the people on your side of the table that this has happened. Because what people do not realize or they do not think about initially is at first we talk about the nexus between drug usage and the drug problem with the crime rate, people automatically get homicide rate and the murder rate. Which is, it is an obvious connection because just about—we estimate about 80 percent of all murders are connected to the drug trade. Hard to know, but that is what we assume because of what data we do get from our victims, victim's families and the like. That is where our focus is on.

What people forget is that the rest of the rate, the overall crime rate of your city is mostly by your property crime. People talk about homicides in any city, it is a terrible one, it is the one you should focus on because it is the most serious crime, but is by far the smallest number.

We are talking about property crime, you think how is this fueled. I mean, when people have $50 to $100 a day drug habits, they have to get the money from somewhere. And where they get that money from very often is breaking into cars, breaking into homes, stealing small items, robberies on the street, selling their bodies. Whatever they may be doing they got to come up with the money. And by doing this, and this meaning providing treatment

and treatment dollars to help people get off their addiction, you are helping us, you are helping us all. And you make my job a whole lot easier.

And the one thing that I am very happy to report today is that not only do we have this very substantial violent crime drop in the past 2 years at approximately 23 percent, but this year our overall crime is down dramatically about 21 percent for part-one crime, which includes all the crime, murder rate, robbery, burglary, auto theft, and the like. That is what I am really encouraged by.

The murder rate is coming down and it is coming down every year. And we are very, very happy with that. But what people have to look at is our overall crime is coming down. And I am convinced that this has to do with it. Because in the last 2 years, as you have heard from the Lieutenant Governor and the mayor, we have had a tremendous drop in emergency room admissions. I think, and I believe you will hear from Dr. Beilenson later, we may be leading the country. And I am convinced this is way we have been so successful. This is a partnership between the police and the health community. We cannot do it alone. And we have been saying that since we got here. You are not going to arrest your way out of the crime problem in any city. It is part of what I do. That is the side of the business I am in is the enforcement side. But without the intervention of the health community and all of the things that they are doing, we would not be nearly as successful.

So I would just like to say as the head of the police agency for the city that we are very much in support of drug treatment. And I just want to get on the record by saying so. I have said in the past the smaller venues but they are not mutually exclusive. And the police department is very, very much in support of drug treatment dollars coming this way.

I just want to thank everyone for hearing me out today.

[The prepared statement of Mr. Norris follows:]

Testimony of Edward T. Norris
Police Commissioner
Baltimore, Maryland
Congressional Field Hearing before the
House Criminal Justice, Drug Policy and Human Resources Subcommittee
March 5, 2002

Chairman Souder, Congressman Cummings and members of the Subcommittee, I am Edward T. Norris, the Police Commissioner for Baltimore City. Thank you very much for coming to Baltimore today to learn how law enforcement and public health professionals are working together to decrease both crime and drug addiction.

Since my appointment in April 2000, I am proud to say that the men and women of the Baltimore Police Department have accepted the challenges that I put forth to make Baltimore a safer city. We have implemented many reforms including the initiation of a unit that uses surveillance tools to break up the City's large and complex drug rings. We have created a warrant unit that works 24 hours a day, seven days a week in apprehending all of the wanted criminals in Baltimore in an expedited fashion so that they do not have the opportunity to continue to victimize our citizens.

When I came here in 2000, all of the crime numbers were going in the wrong direction. The City had just had another year of over 300 murders...topping off a decade where over 300 individuals were killed ever year. That means that since 1990, Baltimore had lost over 3000 citizens to this most violent offense. This year, we had 258 murders. Still too many but this indicator tells us our reforms are moving things in the right direction.

What drives our murder rate? Narcotics. According to a July 2000 Drug Enforcement Administration (DEA) study, Baltimore leads the nation in per-capita heroin use. The DEA said that Baltimore is estimated to have at least 60,000 drug addicts - roughly 10 percent of the population. We can confirm that drugs are a factor in eight of every 10 City homicides.

The assessment, based on DEA intelligence and statistics, as well as independent research, concluded Baltimore is the "most heroin-plagued" city in the United States and has one of the most severe crack cocaine epidemics in the nation. Further, DEA officials have told me that at least $1.5 million in cash is exchanged every day during street-level drug deals.

We were successful in working with our Federal delegation and explaining these facts last year to receive a $24 million Department of Justice COPS grant for 200 new officers. These officers are just now hitting the street and will have a tremendous impact in the communities they serve. However, the Mayor, our Director of Public Health Dr. Beilenson and I agree that with the addiction crisis in Baltimore, there is no conceivable way that we can arrest our way out of this situation; nor would we want to. ***By pairing effective law enforcement strategies with equally effective drug treatment programs, Baltimore has seen improvements that many doubted would ever be accomplished.*** We are at a critical crossroads. I hope members of this Subcommittee take this opportunity to learn more about our successes and commit to increase funding to strategies which pair effective law enforcement tactics with proven drug treatment programs. Thank you for visiting our City and for your dedication to this issue.

Mr. SOUDER. I want to thank each of you for your testimony. I am going to yield to Congressman Cummings for the first 5 minutes of questions.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. And I want to thank all of you for being with us today. And I want to thank all of you for being about the business of building lives and not just sending people that got into trouble and let us just sort of throw them away and move on. And that means a lot.

Commissioner Norris, one of the things that when the drugs hearing at the Tuerk House 2 weeks ago and the mayor and Lieutenant Governor were there, afterwards I did a little survey of some of the people that were in the room, 12 people. And of the 12 people I asked what was their average when they were using drugs, how much money did they spend during a period when they were unemployed. And the average person was $110 per day. That is a lot of money.

So it goes back to what you said about the property crimes. If you are not employed then you, you know, you spend $110 a day, I mean, even us to spend $110 a day, that is a lot of money. And so it has got to come from somewhere And I, you know, I was just thinking as you were talking, probably a better barometer, a measurement, measuring tool of effectiveness in regard to crime would be the property crimes.

Because, and I have said this to you, Mr. Mayor, I think it is when I look at the murder situation, it is hard. I mean, because you have got to have some—the only way I can see you really getting to the murder situation most effectively is intelligence. I mean, if someone wants to harm somebody, then they are going to do it. I mean, and unless you know it, it is kind of rough. But I mean, I applaud you. And I really mean that for doing what you have done.

Let me just ask you, Lieutenant Governor, about this whole thing of working with people after they get out of prison. The chairman and I would guess most of the members of our subcommittee are very impressed with this New York Program. And you all may want to comment on this, too. The VTAP Program where one of the elements of the program is that they finds job for these folks. Because one of the things that they noticed that people go right back to the same corners.

Ms. KENNEDY TOWNSEND. That is correct.

Mr. CUMMINGS. I think the mayor was talking about this the other day, they go right back to the same corners. And the next thing you know they are back in jail or they are back dealing drugs or whatever. And we see this revolving door.

Ms. KENNEDY TOWNSEND. Right.

Mr. CUMMINGS. And one of the things that apparently, assuming that you have counseling and then treatment and all that kind of stuff, and if you can help them find jobs, it seems that would be one of the key elements that so many programs do not have.

Ms. KENNEDY TOWNSEND. That is exactly right. Thank you for asking that, Congressman Cummings. As you may know, the State of Maryland has launched three initiatives to help stop the recycling of prisoners back into prisons, to help offenders get their lives together.

One of the things we have learned is that one of the biggest challenges is in fact housing. That people come out of prison and they do not have a place to live. And so one of our efforts has been to focus on housing. Combined with that is obviously job training, some of which occurs in the prison, some of it occurs when they are on parole and probation under supervision. Drug treatment, very critical.

As you know and as you said, 11,000 of the people on parole and probation are in our Break the Cycle Program. They are in a drug treatment program. And so what they need is housing, they need roots in the community, they need job training. We have launched a number of efforts to connect people who are getting out of prison with mentors in the community, with job interviews. We have done a number of, you know, efforts to make sure that they learn how to have a job interview, as well as drug treatment.

If you combine those three aspects, I think you can really make an impact. In fact, the Justice Department has highlighted one of our programs already. And we hope in the coming years that we will grow them based on what we learn from these three initiatives.

But each is really crucial, the housing, the drug treatment and the job training. As well as, helping the person get the job.

Mr. CUMMINGS. Mr. Mayor and Commissioner Norris, what have we learned that from your experiences that we could transfer to other cities as far as effectiveness of bringing down the crime rate with regard to drugs? I mean, we are always talking about looking at other places. It seems like we have been very effective here. And I am sure you all have learned some things since you have been in office. And I was just wondering what kind of things, because we are always trying to figure out what we can take from one place and take it to a higher level, more or less national. And I am just wondering what have you learned in this process? I know it has only been a short time.

Mr. O'MALLEY. I think the most important thing that we have learned here, Congressman, is that it is not an either/or proposition. You have got to do both. The former Drug Czar said, you know, in Washington we have these debates all the time about whether we move enforcement dollars into treatment, or whether we move treatment and interdiction dollars into enforcement. He said, and the truth of the matter is, it is like pouring a half-full glass back and forth thinking that sometime, you know, it might fill up one of the two glasses. The truth of the matter is we need to do more of both. That is the most important lesson that I think has come out of Baltimore.

Commissioner Norris is far more expert at the enforcement end of things. And Dr. Beilenson is here. Speaking just briefly for him, I do not know if he testifies later, but the wraparound services we found has been critically important.

You can create a whole bunch of additional slots. Or you can improve the quality of the treatment you are providing in terms of the random urinalysis or the job placement or helping people get stable homes. And I think those things are thing that he will probably tell you have we have learned ourselves over these last couple of years as we ramp up with the additional dollars. That more slots does

not necessarily mean that you are more effective. But more effective slots mean you are able to treat more people in a more lasting way.

Mr. CUMMINGS. Before we get to you, Commissioner, I met yesterday with the Enterprise Foundation, Mr. Mayor. And they were telling me that they are coming up with this program to help people when they come out of prison, to try to, you know, do a lot of things for them. Basically, it was what the Lieutenant Governor and you just said, give them the kind of support system. And I was wondering are there entities to your knowledge that are doing the same thing that is outside of government? And I mean, is that something that we should look forward to more folks doing?

Mr. O'MALLEY. I know that the, maybe Dr. Beilenson might be able to speak more to this. I know that the Open Society Institute had some initiatives that they were starting to roll out.

I think this is a battle for all of us. You know, too often we think that it is up to government, everything is up to government. Well, it is true that only government can swear police officers and give them the badge and the gun and those arrest powers. While it may be true that government has a big role to play in providing treatment for those who are uninsured, the fact of the matter is, this battle is everybody's battle.

So I would hope that as we progress and as we start establishing this track record as a national leader, that success will become contagious. And the churches will realize that indeed there is a calling and there is a mission for every church to be involved in the lives of people coming out of prison and helping them become more stable, productive members of society by reaching out. But Dr. Beilenson may be able to know more of the other program.

Ms. KENNEDY TOWNSEND. And just on that, I would say that we have a productivity council at the State of Maryland. And it was chaired by Jack Kingsley, private industry. And he started this effort to recruit businesses to be mentors and to do job training and to do—helping with people coming out of prison.

Because he understood, first of all, we had a job shortage for a long period of time, as you know. And they wanted to make sure that they were getting as many people employed as possible. So there was a lot of self-interest on the part of the business community to make sure that they were working with people coming out of prison. And it has been productive so far. As you know, it is one of the three initiatives that we have launched.

But and I would say one other thing, and I just add on to what the mayor said about what works. I think there was an article in the New York Times a couple of weeks ago that said very clearly, the longer somebody is in treatment, the better chance they have to get off of drugs. And so to the extent that we do not focus just on slots but how long somebody can stay in the slot and what incentives we can get to somebody who stays in treatment I think the better off we are.

And I think that is why Break the Cycle has been effective. But that is why other programs work the best, if you can get them to stay in the program for a longer period of time. Because that is really what works the best.

Mr. CUMMINGS. Mr. Beilenson, I mean, Norris, I am sorry. I apologize.

Mr. NORRIS. That is all right, Congressman. Just to reiterate what the mayor and Lieutenant Governor just said again and give you a brief description of how we run the Police Department now.

The basic philosophy in our police and strategy is that here as in other cities, you have got small core criminals that cause you all your grief. And you are focusing in on that small core. And the better you do addressing them the faster your crime rate goes down. The same philosophy applies to the drug treatment. And I will explain why.

The violent criminals are obvious. The predatory criminals that shoot people, they do not commit one shooting, one murder, get a square job and go drive a truck the next day. They made a decision at this point in their lives very often as adults. But we catch these people and very often they go to prison and for long periods of time.

What is helpful about having people in effective drug treatment, and this is again just to back up 1 second, as you stated before with the murder rate, people always focus on the tie between the drug problem in America and the murder rate. And it obviously is tied but at a different level. It is how you have to deal at the top. The people that are providing this poison for our streets are the ones that are shooting each other for business purposes. And they always kind of confuse the two.

Where the overall crime rate that we are talking about here is driven by the people who are abusing the drugs and being fed this stuff than the drugs dealers. And they are two very distinct things. The very serious violent problem we focused on, they are all these business wars going out there. The fighting over turf, product that may be sold and may be missing, moneys and the like. For the junkies on the street, the people that are using and are caught in this addictive cycle, as we talked about before, it is about $100 a day, $110 when you spoke to these folks. That is what we hear.

The point is, the way we run the Police Department, you got a person who is committing a series of crimes in every neighborhood, be it robberies, burglaries and the like. The quicker you identify them and bring them to the bar of justice, your crime rate goes down because they do not commit all the crimes they would had they been left out there.

It is in the drug treatment. If you got people who are in need of treatment and are unemployed, and they are going to be unemployed if they have a drug problem. They are not going to hold onto their jobs if they are addicted to any kind of alcohol, drugs, whatever. They are going to be unemployed sooner or later. They are going to get the money somehow. And that is going to be by the petty crimes we talked about.

The more people get into drug treatment and get back on track and get their lives back in order, get them housing, get them jobs, get them off this terrible addictive cycle they are in, again, that is going to bring your crime rate down. And that is the business I am in, is looking at the bottom line of crime reduction every day. And that is why I am such an advocate for treatment.

Because it is very helpful for us as we look at the whole crime picture in the city. If you take, even if you cannot address, you are

never going to get everybody off drugs in any city. But the more people you help incrementally, you bring people off, you get their lives back, make them productive citizens again, you reduce your crime rate by that much because each one of those people is back at work, hopefully, not committing crimes to feed their habit. And all those victims that would, you know, ordinarily be victimized no longer are.

Because if it is, you know, if it is 100, if it is 1,000, you just multiply that by crimes they would need to feed their habits. They are not committed in the future and your crime rate goes down substantially.

And that is what we have learned.

Mr. CUMMINGS. Thank you.

Mr. SOUDER. Commissioner Norris, one of the interesting steps that I was recently told, I have always assumed that 60 to 75 percent of all crime is related to narcotics and alcohol abuse. But I had a civil judge come up to me and tell me that in his court cases he felt it was also true in child support, divorce cases. And in the civil side, usually we talk the criminal side, but it is interesting that drug and alcohol abuse is the No. 1 reason, by as you mentioned, people do not hold jobs, they can't pay the support to take care of their kids. And it is even more than just a violent crime.

I had a kind of—let me ask, I have two questions. One relates to what is actually being done while people are incarcerated. That I heard you say that juveniles have a probation program targeted for that in Drug Court.

Ms. KENNEDY TOWNSEND. And for adults.

Mr. SOUDER. And for adults for probation.

Ms. KENNEDY TOWNSEND. And parole.

Mr. SOUDER. And parole. Is anything done while they are in prison to anticipate? One of the things that happened a number of years, excuse me, a number of years ago was we increased the number of people who were locked up. Now many of them are starting to come back out on the streets. Part of our decline in crime around America is because we simply took the criminals off the street.

Now we are faced with they are coming back out. In Indiana the law states they have to go back into the neighborhood they were originally arrested, which means that neighborhoods that have respectively been cleaned up are now about to get another wave in.

Have you started to anticipate that, have you worked in the prisons and what are you doing in that area?

Ms. KENNEDY TOWNSEND. Yes. We do have drug treatment in the prisons. We could clearly have more in the prisons. But we have also made a choice to put most, many of our drug treatment dollars for the people that are on parole and probation.

Because as I said earlier, 60 to 70 percent of cocaine use and heroin use is used by these individuals. These are the individuals who are already out in the streets and in the neighborhood. So they are most—they use the drugs on one hand, and they are most dangerous to the community on the others. And very frankly, if we get them off of drugs, we will reduce the need for cocaine and heroin, you know, on one hand. And we will reduce the crime rate on the other.

So it was the choice, very frankly, of where we put our treatment dollars. We do have drug treatment in the prisons. But we have focused mostly on those who are going to be greatest harm to those on the streets.

Mr. NORRIS. From the city side, I am not really the person to speak for this. It is not a police issue. But I do know from the mayor's strategy at the cabinet meetings, one of the things we have done is there is, embarrassed to say, they provide jobs for folks in the city. They get the job training and actually find employment for people who need it in Baltimore City. Bonnie Siepel runs the program. And one of the things they have done is they have asked us for releasees and the like who were getting, you know, coming back to neighborhoods who just recently were released from prison. And they have gotten businesses to agree to take these folks on board. So in response they will actually provide employment for them once they come back to the city.

And so the short answer is yes. There is a program and strategy in place to actually get people jobs when they came out.

Mr. SOUDER. So that process starts 3 to 6 months before they are to be released?

Mr. NORRIS. That is right.

Ms. KENNEDY TOWNSEND. That is exactly right.

Mr. SOUDER. And also, Governor Townsend, maybe you can address this. Do you see differences in the—we are always in a dilemma in Congress and everybody who talks about drug treatment has this, or drug abuse has this same problem. On the one hand, we say everybody uses drugs, it is equally spread around the country. Yet when we normally look at the violence figures they are greatest in the lowest income.

We talk about housing needs, we talk about job need, which generally implies that the problem is predominately in low income. Certainly, the criminal side is because often that is where people come in and wreck the neighborhoods in the low income area where the dealers are.

What I wonder is, do you see differences in suburban, rural trends from urban Baltimore, are you nuanced in the strategy in Maryland? What kind of pressures do you see? Because I assume that in Maryland, as it elsewhere, drug usage is not just concentrated in the urban center.

Ms. KENNEDY TOWNSEND. No, no. It is not.

Mr. SOUDER. And what are the patterns that are similarly——

Ms. KENNEDY TOWNSEND. No.

Mr. SOUDER [continuing]. Economic or, and then how do you adjust when you are looking at drug treatment?

Ms. KENNEDY TOWNSEND. That is a very good question. In fact, we have the University of Maryland something called the DEWS system. The Drug Early Warning System, which has showed us what kind of drugs are used in different parts of the state. And very frankly, I would love to submit as part of my testimony a description of who uses what drugs where. And it changes.

As you have heard, Baltimore uses a lot of heroin. In the suburban areas ecstasy has become more popular. There are other parts of the state that really focus more on alcohol. And I think down to

Washington, if my memory serves me right, this is from looking at this about 6 months ago, cocaine has been more used.

So we do have different strategies. And that is why we have this evaluation system that says what kind of treatment is best for what kind of user. I would say, however, that I think a lot of people use drugs wherever they are, you know, some of our toughest neighborhoods, as you may know. And I say this before, my brother who clearly did not grow up in that tough of a neighborhood, died of a drug overdose. My other brother was a heroin addict for 15 years. So I think it is important.

And on the radio this morning on an ad that says drug treatment works, they were talking about a neurologist who had been overdosing on prescription drugs. So I think—and which is also a terrible abuse. So I think it is important for us all to understand that drug abuse hits everybody in some place or another. It could be alcoholism, it could be heroin overdose. And what we are doing at the state level is evaluating what works in what places because we do have very different profiles of who is taking the drugs and what drugs they use..

Mr. SOUDER. Congressman Cummings, do you have——

Mr. CUMMINGS. Just one other thing, Lieutenant Governor. There is a program which the State had something to do with. And they—which has been very effective in getting jobs for Preston—and the reason why I know so about it is his office is literally across from our office. But the State Department of Economic and Employment Development worked with them and the unions. It is an amazing situation. And they are—the unions are helping to train folks who are coming right out of prison.

Ms. KENNEDY TOWNSEND. Right.

Mr. CUMMINGS. Starting them at $9 to $11 an hour. And this agency actually monitors their conduct and whatever. So and they just told me, Mr. Daley just told me the other day that they have gotten Wyatt and Turner, one of our big contractors in this area, well, across the country really, just guaranteed them 300 jobs. So this thing can be done.

Ms. KENNEDY TOWNSEND. It can be done.

Mr. CUMMINGS. Yeah.

Ms. KENNEDY TOWNSEND. We are now much more focused on the transition into civilian life than we had previously. We had been focusing on other issues. But now that we are putting more drug treatment, we are going to do the wraparound services.

And I am glad you focused on it because it has been—I think we need that. We also need in prison, besides drug treatment, education. Because there is a strong correlation between how educated people are and whether they are recidivate.

So if you are looking at ways that Congress could help, more money for drug treatment, more money for education in the prisons I think would make a big difference. And more help with training.

And I know that in the President's budget he cut some of the drug treat—he cut some of the training dollars, you know, job training dollars. And I would ask that you look at that. Because that could be very useful as well.

Mr. CUMMINGS. I think by the time the budget finishes it may be quite different than what the—what we started out with.

Ms. KENNEDY TOWNSEND. That is why you get to be elected to Congress.

Mr. CUMMINGS. Yeah, yeah. Thank you. So I want to thank both of you, and of course, the mayor, for being with us today. I know your schedules are very busy. And I just encourage you all to stay on the path. Because the people that you are affecting every day in a very, very positive way that will never come up to you and say, thank you.

As a matter of fact, some of them may be upset with you. But the fact is, that a lot of good things are being done to help lift them up and their families. And so we really do thank you.

Ms. KENNEDY TOWNSEND. Thank you, Congressman.

Mr. SOUDER. Thank you. And I want to assure you too, that in the budget process that it is like labor negotiations, an opening offer. And it always embarrasses the President if some Member from the other side puts their budget up. I think Reagan's budget got two votes when he was in. Clinton got one vote, the person who is steadfast. And I am sure a similar thing would happen here. In fact, one of the things I am not doing this morning was speaking to a job training conference. And Welsh and I sit on that subcommittee also.

Ms. KENNEDY TOWNSEND. Oh, good.

Mr. SOUDER. And I can assure that the job training money never goes down. It is questionable whether it is going to be flat or how much it is going to go up. Because it is so, particularly with the softness of the economy. But I do want to thank you——

Ms. KENNEDY TOWNSEND. Thank you.

Mr. SOUDER [continuing]. For your efforts. And understand that these problem are very complex. Often when we see exciting new programs like Drug Court and some of these programs the expectations can outstrip reality.

Ms. KENNEDY TOWNSEND. Right.

Mr. SOUDER. The truth is is that people's—the reason people get involved with this is very complex. And it is not like they are all going to suddenly be turned around. And as the general public understands that when we work with drug treatment or drug prevention, it is incremental. And hopefully, we can all be successful.

And thank you for your efforts.

Ms. KENNEDY TOWNSEND. Thank you very much. I appreciate it.

Mr. SOUDER. If the second panel could come forward. Ms. Renee Robinson, the Honorable Jamey Weitzman. And maybe you can just remain standing so we can do the oath.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that both witnesses responded in the affirmative. Ms. Robinson, could you go ahead with your testimony.

STATEMENT OF RENEE ROBINSON, TREATMENT AND CRIMINAL JUSTICE PROGRAM MANAGER, WASHINGTON, DC–BALTIMORE HIDTA

Mr. ROBINSON. Good morning. I would like to thank everyone for the opportunity to come in to share about the work that we are doing at the Washington Baltimore HIDTA.

I am the Treatment and Criminal Justice Program Manager at the HIDTA. I am responsible for the 12 initiatives that are part of the Treatment Criminal Justice Project. And those 12 initiatives are spread throughout the region and the State of Maryland, northern Virginia, as well as, the District of Columbia.

And what HIDTA provides—what actually HIDTA is funded through the Office of National Drug Control Policy. And we are now affiliated with the University of Maryland, who is our fiduciary. So subsequently, the University of Maryland provides subcontracts to these jurisdictions to expand or enhance their treatment services continuum.

HIDTA funds are very flexible in that we have opportunities to support the Break the Cycle effort. Our model and our philosophy is very similar to Break the Cycle. So subsequently, while HIDTA funds will provide additional treatment slots in the Break the Cycle jurisdictions, we stress a continuum of care for the offenders who are involved in the HIDTA Project. We require that they are extensively supervised. We also want them to be drug tested on a frequent and regular basis. And we try to retain them in treatment as long as we possibly can. So subsequently, the outcomes for the offenders who are involved in HIDTA funded treatment are very good.

We had at our last evaluation a 70 percent reduction in recidivism over the 12 jurisdictions that were involved in the Treatment and Criminal Justice Initiative. And I think that is pretty outstanding considering the rate of recidivism that you find in most programs.

One of the things that HIDTA does is stress accountability and responsibility for the offenders who are involved in our program. That is a cornerstone. I have been involved in providing treatment services in jails and prisons throughout my entire adult career. And one of the things that I found to be most problematic was the fact that offenders often times slip through the cracks while they are involved in supervision. And subsequently, were not held accountable for long periods of time after they committed crimes against the communities.

And what HIDTA wants to do is to approach treatment not from a hug-a-thug mentality, but one of responsibility. One, to make sure that these offenders, if they commit crimes against the communities, are held accountable for our sanctioning process. That the drug use stops, that they are tested to insure that they are drug-free and that they are crime-free while they are involved in our projects.

And we focus on best practices. We fund programs that have been proven to be effective with the offender population. We are not specifically based on a medical model. Although we have an eclectic, we allow the program to have an eclectic approach to the treatment services that they offer. But what we want them to stress is addressing the criminality. Addressing the criminal thinking pattern, the criminal behaviors that continue to allow these offenders to commit crimes in our communities. And once we have an opportunity to address these issues with these offenders, super-

vise them closely while they are an offender, and excuse me, while they are in the programs, then we see significant reductions in their criminal behavior while they are involved in HIDTA funded treatment.

[The prepared statement of Ms. Robinson follows:]

Written Testimony for Public Hearing on: The Effects of Drug Treatment Funding on Public Health and Public Safety in Baltimore: The Benefits of an Integrated Demand Reduction Strategy

Submitted by: R. Renee' Robinson, MPA
Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA)
Treatment/Criminal Justice Program Manager

The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) was initiated through the Office of National Drug Control Policy (ONDCP) in 1994. The W/B HIDTA is considered a prototype because it has developed a multidisciplinary approach, which encompasses law enforcement, treatment, criminal justice and prevention components. Twelve jurisdictions throughout the region participate in the treatment/criminal justice component.

The primary goal of the HIDTA treatment component is to reduce the demand for drugs for hardcore drug addicted offender. The demand reduction approach recognizes criminal justice supervision and treatment interventions for hard-core offenders as effective tools. By improving outcomes of hard-core offenders, changes can be expected in their substance abuse consumption and criminal behaviors.

The second goal is to improve the treatment services for hard-core offenders. The objective for this goal addresses enhancing or developing a continuum of care and using HIDTA funds to provide one part of the continuum. Both treatment interventions and sanctions are incorporated in the process, expanding the use of community resources and addressing critical gaps in services.

The third goal aims to improve communications by developing regional and local management information systems. The objectives for this goal are to create an automation system for both treatment and criminal justice systems in each jurisdiction. The automation will allow for prompt and appropriate information sharing across systems within the jurisdiction as well as across the region.

The cornerstone of the HIDTA criminal justice and treatment initiatives is the development of a seamless system in each jurisdiction. A seamless system is defined as a service delivery system that links criminal justice and treatment agencies together with umbrella policies and procedures. The participating agencies collaborate in both decision-making and managing the offender in the community. Involved agencies determine the necessary functions to be performed within their service delivery system, and these functions are mutually defined and agreed upon. The system then has policies linking all the agencies together to perform the designated functions. A seamless system has an integrated service mix. Integrated service mix is the synthesis of the criminal justice and treatment systems where options from both systems are available in responding to offender progress as well as noncompliance. An integrated service mix requires participating agencies to span the boundaries of their separate agencies and systems.

This mix increases coordination between agencies and reduces duplication of services. This process requires that the agencies identify priorities and utilize scare resources in the most effective manner. Finally, agencies must define how the separate entities will be integrated to meet the task and functions of the service delivery system.

The other set of policies necessary to create the seamless system involve graduated sanctions. Graduated sanctions are a set of planned and progressive responses to noncompliant behavior. They involve three principles 1) swiftness of responses to noncompliant acts 2) certainty of responses 3) progressiveness of severity of responses. Use of these concepts increases the consistency in the delivery of responses to behavior. Both criminal justice and treatment systems should enforce these sanctions. The integrated application of graduated sanctions is aimed at holding both systems, as well as the offender accountable. Unity and cohesion is ensured between systems and reduces the manipulation of either system by the offender.

The development of drug testing polices is also an important care component of the seamless system model. These are written policies stating the schedule of drug testing for offenders. The schedule is administered consistently and is frequently a part of the criminal justice sanctions policies.

Since the Treatment/Criminal Justice initiatives involved in the W/B HIDTA vary significantly in their composition, different aspects of the seamless system are being addressed in different ways in each jurisdiction. Although the specifics vary, the general approaches across jurisdictions are similar.

In my role as Treatment / Criminal Justice Coordinator at the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) I am tasked with the responsibility of providing administrative oversight and guidance to local jurisdictions involved in the HIDTA project.

More specifically, the Treatment/Criminal Justice initiative supports the mission of the W/B HIDTA by supplementing local jurisdictions budgets in adopting the innovative HIDTA treatment models for the hard-core substance abusing offender population. This is accomplished by intensifying treatment conditions, drug testing, supervision and the sanctioning process for offenders to ensure compliance with conditions imposed by the courts. The model also stresses offender accountability and strives to increase successful outcomes for the offender population while involved in the criminal justice system. The Washington/Baltimore HIDTA's model attempts to improve and strengthen the existing treatment system in the region by providing small grants to the localities involved in the HIDTA project to expand, establish, and enhance the localities existing treatment continuum.

The HIDTA endeavors to assist the localities in developing a systematic approach to the development of a continuum of care for the offender population that they serve. Most of the HIDTA funded programs in the localities are comprised of the jail based treatment connected to treatment in the community, residential treatment connected to treatment in the community (intensive outpatient) or intensive outpatient with outpatient care.

"The term" continuum of care is a frequently mentioned process whereby the offender is moved along service levels depending upon the stage of the needs of the offender- from detoxification, inpatient or residential programs, intensive outpatient programs, outpatient programs, relapse prevention and support networks. Andrews and colleagues, (1990a, 1990b) comment

The Washington/Baltimore HIDTA program implemented a study by Dr. Faye Taxman "which tracked one thousand two hundred sixteen offenders (1,216) who participated in HIDTA funded treatment in 1997. The offenders had to have been placed in a HIDTA funded treatment program during that period of time. All of the that treatment placement decisions should be affected by the offenders risk level to determine the amount of controls and structure needed to augment treatment and criminal justice outcomes. For example, higher risk offenders may need a residential setting or day/evening programs because of the propensity to engage in criminal activity. The residential or day/evening setting provides external control on the offender's behavior by limiting the amount of unsupervised time. However as research indicated, this intensive treatment must be followed by less intensive treatment/services to gain the full effect of treatment on client outcomes. (Lockwood, et al, in press, Weinman and Lockwood, 1993; Taxman et al, 1995).

Under the care management approach, the continuum of care must involve two different types of service features: (1) cross sectional, so that services provided by an individual at any given time are comprehensive and coordinated; and (2) longitudinal, so that the system provides comprehensive integrated services over time and is responsive to changes in the person's needs. Continuity of care holds special significance for ADM (alcohol, drugs, and mental health) patients because of the chronic, relapsing nature of many ADM disorders, which often require a lifetime of interventions (Baker, 1993:4).

The concept of a treatment process recognizes the importance of multiple stages and episodes of treatment. Treatment as a process allows for movement along a continuum to provide comprehensive services to address the social, psychological, and economic needs of the offender. A continuum of care also retains the client in treatment system to produce better outcomes offenders were tracked for six months in the community. The study found that the average HIDTA client has ten (10) prior arrests and five (5) prior convictions with forty three percent (43%) reporting daily use of illicit drugs. The likelihood that offenders would be arrested in a six-month period of time prior to involvement in (Prendergrast, et al, 1994; Lockwood, et al, in press). Services have been discussed as phases of the recovery process: 1) primary treatment interventions or therapeutic interventions addressing the underlying psychosocial factors that affect substance abuse and criminal behavior, 2) moderate treatment including educational, vocational, life skills, counseling, housing, etc., and 3) support services including relapse prevention, booster sessions, support groups, employment assistance, etc. Under a continuum of care philosophy, these services need to be delivered in phases consistent with the recovery process. The quality and quantity of these services vary considerably. For the criminal justice offender, it is recognized that the phases need to consist of some intensive interventions followed by aftercare or counseling (Atshuler and Armstrong, 1991, Taxman, et al, 1995). The continuum provides for a continuous involvement in the treatment system. Research has found that few offenders are provided with a continuum of care as they move through the criminal justice system.

The seamless system approach encouraged by HIDTA increases the likelihood that a continuum of care is implemented. The integration of treatment and supervision allows an offender to move along the continuum as appropriate in regard to both treatment and criminal justice needs. For a non-compliant offender more intensive treatment can be required by the criminal justice authority to ensure movement up the continuum. For the successful offender, less intensive treatment can be coupled with continued criminal justice supervision to provide a safety net as the offender transitions to the community.

HIDTA treatment was twenty two percent (22%). After assignment to HIDTA treatment, eleven percent (11%) of the offenders were rearrested in a six-month period, which is a decrease, by fifty percent (50%) of the probability of arrest.

Beside the reduction in re-arrest rates, the study found that retention in treatment was high among participants. Over eighty percent (80%) of the offenders completed or were still active in the first phase of treatment with sixty-five (65%) being involved in at least two phases of treatment. The average length of stay in treatment as of December 31, 1998 was one hundred sixty days with most offenders still active in some part of the treatment continuum. This contrasts to the findings of DATOS where only fifty percent (50%) of the criminal justice referrals completed treatment." (Taxman et al., 1999)

The following table reflects the findings of the study as it relates to the retention of offenders in HIDTA's continuum of care.

Site	%Complete Phase 1 or Still Active	% Continuum of Care	Mean Length of Stay in TX
Alexandria City	64	52	168
Arlington County	88	48	270
Fairfax/Falls Church	88	78	158
Loudoun	72	65	197
Prince William	64	67	315
District of Columbia	86	77	203
Baltimore City	80	55	122
Baltimore County	86	82	131
Charles	88	90	189
Howard	81	80	269
Montgomery	78	55	193
Prince George's	69	46	126
Overall	81	65	166

The Washington/Baltimore HIDTA is in the process currently of evaluating a co-hort of offenders involved in HIDTA funded treatment for a one-year period. The evaluation is being conducted by Dr. Robert DuPont, Institute of Behavioral Health. This study follows a co-hort of offenders involved in HIDTA treatment during calendar year 2000. Preliminary results of the study also conclude that the HIDTA model is significantly impacting and reducing recidivism rates in participating localities. The results of this study will be available for publication in June of 2002.

The continuum of care management model allows offenders to receive the appropriate level of services for a direction of time required to allow the offender to address his criminal lifestyle, thinking errors and substance abuse. Episodic treatment interventions have served to create significant gaps in the service delivery system that the offender population has successfully manipulated. If offenders are not afforded an opportunity to participate in a seamless system with a well-defined continuum of care, opportunities are lost to impact and reduce the escalating crime and drug crisis that we face in this country.

Subsequently, outcomes from the Washington/Baltimore HIDTA project has shown that funding substance abuse treatment programming for the hard-core offender population through public health agencies provides significant benefits in reducing both the demand for drugs and the resulting public safety menace that prevails in our local and national landscape.

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Biography for R. Renee' Robinson: Ms. Robinson serves as the Treatment/Criminal Justice Program Manager for the Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) Program, a project by the Office of National Drug Control Policy and funded through the University of Maryland. This project involves law enforcement, treatment/criminal justice, and prevention components in a concerted effort to reduce the drug problems in the Washington/Baltimore HIDTA region. She offers over twenty years of experience in correctional program development and management, grant writing/management, policy development, program evaluation and analysis, human resources, and budgetary management. Her professional expertise includes institution and community based corrections, as well as the development and facilitation of training for the criminal justice staff. Ms. Robinson served as Program Director for the world's largest single purpose substance abuse treatment facility for offenders in the Eastern part of Virginia. Ms. Robinson holds her Masters in Public Administration from Virginia Commonwealth University and plans to pursue her Ph.D. in Management.

Oral Testimony- Congressional Field Hearing: "Benefits of an Integrated Demand Reduction Strategy: Effects Of Treatment Funding on Public Health and Public Safety in Baltimore" March 5, 2002 Submitted by: R. Renee' Robinson, MPA Treatment/Criminal Justice Program Manager Washington/ Baltimore High Intensity Drug Trafficking Area (HIDTA)

As we discuss, strategize, and attempt to problem-solve this issue, it is critical that we not continue to allow ourselves to repeat the mistakes of the past. We know that traditional intervention strategies utilized with this population has not produced the reductions in the crime rate and drug use that we had hoped. Service delivery systems have been somewhat fragmented and disjointed. Individual agencies have their own established turfs and territories and have been slow to embrace the concepts of collaboration and communication between and across boundaries to truly create a criminal justice system. Funding concern spanning across these agencies have contributed to their reluctance to embrace the collaboration model. However, as we move into the new millennium business as usual must cease.

The W/B HIDTA has provided a platform to institutionlized best practices and develop systematic responses to this dilemma. The movement away from individualized decision making regarding offender management by one system is critical. Anecdotal stories abound from offenders who have loop holed the system because agencies experience difficulty in communicating effectively. Offenders have been released from jail or prison with little to no after care services, or if they are provided there is no communication between those agencies to ensure that whatever gaps in treatment the offender experienced in the previous setting will be followed through in the next phase of treatment.

Substance abuse funding issues should not be made in a vacuum. As funds are allocated for treatment services, we must remember that these services should be provided along a continuum. Rarely will an offender only need one treatment experience. That experience will in all likelihood need to be followed with another episode of treatment that is more or less intensive depending on the offender's compliance with required mandates. Most local jurisdictions provide treatment services to ten (10) to fifteen (15) percent of offenders in need of assistance (Belenko, 1998). The HIDTA sites would not have built the continuum of care or the seamless system model without grant funding from the Office of National Drug Control Policy.

All local and state correctional criminal justice and treatment agencies should seek to form partnerships that build the continuum across agencies to ensure the likelihood of increasing successful outcomes for this population. Expending funds to build the continuum as outlined sends an important message to the public that treatment combined with intensive supervision, appropriate sanctions and drug testing can and does work to more effectively manage the substance abusing offender population. The public will then become more willing to request this approach from public officials who make decisions regarding funding of substance abuse treatment and policy makers who determine priorities in this area. These gains – in terms of reducing offender rates and recidivism among hard-core active offenders are likely as long as a treatment services continuum is established and maintained.

Mr. SOUDER. Thank you very much. Judge Weitzman.

STATEMENT OF JAMEY WEITZMAN, JUDGE, BALTIMORE CITY DRUG TREATMENT COURT, AND CHAIR, MARYLAND STATE DRUG COURTS COMMISSION

Judge WEITZMAN. Good morning, Chairman Souder and Congressman Cummings. It is nice to see you. Thank you so much for allowing me to talk to you about one of my favorite subjects which is Drug Court. I know that from the state and local perspective they are concentrating on coordinated delivery of services. And they have a large perspective. They are looking at the forest. But I draw on trees.

Every day in my criminal court in part two, I see the face of drug addiction. I see the devastation that drug addiction brings. The dysfunctional families, countless children, people who have lost jobs, lost hope, lost self-respect. That is where the rubber meets the road in my courtroom.

And we have been the victim, so to speak, of lack of services and coordinated services for many, many years. That was the basis for the creation of the Drug Treatment Court. It was born out of the frustration of the criminal justice community. That what we were doing just is not working. We were not really addressing the long-term needs that the folks who were committing crimes to support their drugs habits. That voila, we have Drug Court, which apparently I have heard from your comments, you know, quite a bit about, and certainly, Congressman Cummings intimately is familiar with it.

Drug Court is an extremely intensive, it is intensive everything. We provide intensive treatment, intensive supervision, probationary supervision twice a week, as well as, urine testing twice a week. They even get to see me monthly so that I can monitor their services. Perhaps that is one of the hallmarks of Drug Court is the traditional oversight. So through a system of incentives and sanctions, a carrot and stick approach, if you like, we are able to monitor, shape, cajole, encourage, if you will, positive behavior of our addicts. So in 8 years, almost 9 years now of our operation, I am proud to boast that I think this Drug Court, at least in Baltimore City, works.

It is important though that in addressing the problems of addicts that you do not just address the addiction per say. So which is why I think the Drug Court is so successful. Is because we embrace the entire defendant and the needs that they have. We address the issues that they have which contribute to their drug addiction. So in Drug Court we provide housing, we try to address their housing needs. We provide job training and placement, GED training. We have a Drug Court Support Group. We also provide and teach the meditation techniques. And we have developed a community church support group to hook one of our Drug Court addicts up with somebody in the church community to try to help build the bridges that they have so destroyed. It is a very holistic approach.

And it is coordinated. It is coordinated between us and treatment. So while all the components of Drug Court, I would like to think I am a critical component, but actually it does not work without treatment. Because as much nurturing as I can give and finger-

wagging, without the education, without the information, without the counseling that is provided by treatment, it is just not going to work.

And our folks are in dire need of help. To give you just a face of how needy our folks are, the average person who enters into Drug Treatment Court in Baltimore City has been addicted 10, 20, 30 years. They enter into our program with daily heroin, cocaine habits, $40 to $200 a day. Can you imagine the crimes that are being committed to support that? And their criminal records, their criminal history is quite healthy. Now they are not violent. But if it was not for Drug Court, these folks would be heading to jail.

And so we surround them immediately with very intensive programmatic support. And we get them on the right track. And most individuals entering Drug Court attend a 6-week treatment acupuncture program, which is in Baltimore City Detention Center. Ideally after that we like to send them to transition living. Why? Because our folks are in such need of structured living environment that we have found that with the double-punch of the acupuncture program and transitional living, that those who receive those things by far succeed more than those who do not.

But that comes with a cost. Because transitional or inpatient treatment is one, is the most expensive treatment modality. And unfortunately, we do not have the funding ability to treat all of the need. So what we have done to skin the cat, is we have partnered with non-certified transitional houses. And while I am so grateful to the generosity of those folks, it is not ideal. Because we do not have the necessary coordination with a treatment oversight. We have to send those folks to an outpatient program. So it is helpful, it is useful, but it is not ideal.

And so those folks who do not get into Drug Court, we only have 900 slots. That is only the tip of the iceberg in a city of 60,000 addicts. And almost 100,000 criminal cases last year. So the rest of the criminal courts are the ones who have to deal with the overflow. When I do not sit in Drug Court I sit in criminal court. And one only needs to sit in a criminal court or violation of probation docket to notice that we are lacking continued, a continuity of long-term sustained treatment for our folks. So money, of course, additional funding is always the issue. Judge Bell, our chief judge of Maryland, is so convinced of the ethicality the treatment court merits that he established a Drug Court Commission. And as chair of that commission it is my job now to develop a coordinated approach to develop Drug Courts throughout the system and make sure that we have robust and continued treatment for the needy folks in the city, as well as throughout the state.

So I think our path is clear, Congressman.

[The prepared statement of Judge Weitzman follows:]

TESTIMONY OF THE HONORABLE JAMEY H. WEITZMAN

presented to the

Government Reform Committee's Subcommittee
on Criminal Justice, Drug Policy, and Human Resource

March 05, 2002

Good morning Chairman Souder, Congressman Cummings and members of the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy, and Human Resources. Thank you for coming to Baltimore and inviting me to speak. It is indeed an honor to be asked to share my thoughts regarding drugs, treatment and, Drug Treatment Court.

From the State-wide perspective, Lt. Governor Kathleen Kennedy Townsend is determined that there be a coordinated delivery of treatment services throughout Maryland. From the local perspective, our Mayor and Health Commissioner strive to provide a continuity of quality treatment on demand to Baltimore's many addicts with limited dollars. They examine the issues, as they must, from the larger perspective,. However, it is in my court, Part 2, of the Baltimore City District Court, as well as in all criminal courts where the decisions that you make at local, state and federal levels actually manifest and effect the lives of many individuals. It is in my court, Part 2, where human dramas unfold daily, where I see families destroyed, parentless children, dreams forsaken, hopes forgotten, jobs and careers lost. It is in my court where I look directly at the face of drug addiction and the devastation it causes.

Drug Treatment Court was created from the frustration throughout the criminal justice system that what we were doing was not working and from a desire to stop the revolving door of repeat criminal activity and prosecutions due to drug abuse. Baltimore City's Drug Court was one of first in the country and eight years later I am proud to boast its success.

Drug Court is built upon the premise that to stop the insidious pull of drug addiction, we must create a comprehensive system that encompasses and supports defendant addicts while holding them strictly accountable for their behavior. To accomplish this goal, Drug Court provides intensive treatment, probationary supervision and urinalysis twice weekly, monthly judicial monitoring. It also provides a variety of support services to address problems that contribute to addiction such as: housing, job training/placement, GED readiness, life skills training, a support group, meditation and a community/ church support program. Additionally, one of the hallmarks of Drug Court is judicial oversight and trough a series of incentives and sanctions, the Court encourages, cajoles and motivates positive behavior.

All of the criminal justice partners join together to operate this holistic yet strenuous program and each of us is accountable for its success or failure. All the components of Drug Court are important and each partner contributes to its success; but perhaps the most critical of all the critical pieces, that which truly makes the program work, is treatment. Despite our best intentions, nurturing and efforts our defendants need education, counseling and information that only treatment can provide. To put a face to our need. The typical Drug Court defendant has been addicted to heroin and cocaine for 5, 10, 20 and even 30 years. Upon entry to the program they have daily habits of approximately $40 - $200. Their criminal history is extensive, and although nonviolent, each would have received a period of incarceration but for Drug Court. We accept only the chronically addicted who are committing crimes to support their habits and their need is profound.

The majority of our population is in dire need of intensive inpatient treatment to provide structure to their chaotic lives. Upon entry into the program, most Drug Court participants first receive a six week treatment and acupuncture program located in the Baltimore City Detention Center. Ideally, they are then sent to a transitional living facility to continue treatment in a controlled living environment, for we have discovered that defendants who receive this combination of care have far greater success then those who do not. However, the cost of this modality is expensive and we are unable to fully accommodate the need. In the alternative, we partner with private, non-certified transitional living facilities. They provide the needed controlled environment and the defendants are sent to outpatient treatment facilities. While we are grateful for the generosity of our non-certified transitional partners, this arrangement, is not ideal for it lacks site-based treatment. Additional funding is needed to provide appropriate inpatient, halfway house and intermediate care.

Baltimore is a city of approximately 60,000 addicts which translates to an astonishing one of every 10 residents. In the District Court alone there are over 150,000 criminal cases yearly, of which 80 - 85% are estimated to be drug related. Despite its effectiveness, Drug Court only has 900 slots, a fraction of the eligible cases. Therefore, it falls upon the judges sitting in the criminal courts to address the remainder of the cases. The judiciary recognizes that incarceration alone is a poor substitute for comprehensive treatment and bitterly complains of inadequate treatment resources and overcrowded probationary services. One only need attend a Violation of Probation docket to recognize that the system is unable to consistently provide the panoply of treatment modalities necessary to address individual needs.

The Office of National Drug Control Policy estimates that the cost of illicit drug abuse to society is $160.7 billion in 2000. This figure factors health care, criminal justice and social welfare costs as well as the loss of productivity stemming from premature death, illness related to drug abuse and incarceration. Neonatal and societal costs attendant from premature and drug addicted babies further aggravate these estimates.

Judges in the Baltimore City urban setting are convinced of the efficacy of treatment. The Drug Court evinces that through the responsible collaboration of the criminal justice and treatment communities addicts can positively alter their lives. Considering the enormous costs of addiction to our community as compared to the relatively low costs yet convincing success of treatment the course is clear.

Thank you.

Respectfully submitted,

The Honorable Jamey H. Weitzman

Mr. SOUDER. Thank you very much. Congressman Cummings.

Mr. CUMMINGS. Yeah, Judge. First of all, thank you both for being here. And, Judge, I was just wondering just one thing. If jail is a turn do you think for, in other words, you are talking about the carrot and the stick. Do you find that the threat of being imprisoned to be something that people—would cause them not to use drugs?

Judge WEITZMAN. In a Drug Court it is surprising. Folks who can do jail standing on their head do not—they avoid it in Drug Court. Because we only give them 1, 2, 3 day sanctions, maybe a week sanction. It is just enough to make their life miserable. They have been out there long enough to establish a pattern. It just is very disruptive. And I have had long-term addicts and criminals tell me the reason they are clean now is because they are not going back to jail. So, yes, I think it is extremely effective.

Mr. CUMMINGS. In the President's budget, if I recall correctly, I think it is—there was $2 million increase for Drug Courts. And it is already at $52 million. It was, I mean, he increased it just slightly. But it could have been level funded, or some would say it is level funded because of inflation and what have you. But certainly, it could have been reduced. So it seems as if the Drug Czar and the administration have some confidence in Drug Courts. And that is good, especially considering the fact that we are spending the kind of money that we are spending now in the war on terrorism.

And I was just wondering, you know, when you say you have 900 now, first of all, how do they get to you? I mean, how do they get to Drug Court? What is the qualifications?

Judge WEITZMAN. We do have a screening process through the State's Attorney's Office to identify the right people. The right people for us are long-term, chronic addicts who would be heading for a period of incarceration if it is not for our intervention. We take the worst.

Mr. CUMMINGS. Well, I think it works, too. And as far as jobs are concerned, are you able to find them jobs?

Judge WEITZMAN. We do. We have a coordinated effort with a program in the Probation Department. And we are now partnering with the Enterprise Foundation as well to provide more jobs. But the reality is they need living wages as well. The majority of our folks enter the program unemployed. And we have about 90 percent employment rate upon graduation. So we are creating quite a few tax payers. But long-term living wages is something that is always at issue.

Mr. CUMMINGS. Before this you were State's Attorney?

Judge WEITZMAN. Yes.

Mr. CUMMINGS. And before that, the State's Attorney was your first job as a lawyer?

Judge WEITZMAN. Well, my first real job, I used to work in Mexico as lawyer. But that did not count.

Mr. CUMMINGS. The reason why I am asking you that is I am just wondering, you know, I am wondering what whether there is any real surprises to you when you came and got involved in the criminal justice system. It seems as if, you know, in listening to your testimony you were talking about you see. And it sounds like it has a profound impact on you. And there is just so many people,

like I said to the mayor a little bit earlier, who see folks in these predicaments and they have a tendency to devalue them.

Judge WEITZMAN. Right.

Mr. CUMMINGS. And say, you know, they got in trouble. Not they it would be, it seems like it would be easy for a judge to do that. When you see all these people coming at you and they are committing crimes and, you know, to say, OK, let us just lock them up and throw away the key. Not throw away the key, but lock them up.

Judge WEITZMAN. Right.

Mr. CUMMINGS. And I was just wondering, you know, and there is so many people that lack the compassion. And I am just wondering, I mean, how does that come about? Because, see, that is part of our problem in trying to educate people that people still have value. And that maybe they did make a mistake, but that they may have fallen but they can get up if we help them get up. And I was just wondering was there something in your career that caused you to, I mean, maybe you were already like that. But I was just—it affected you.

Judge WEITZMAN. Yeah. As the State's Attorney, actually I was the Chief of the Drug Prosecution Unit. And I used to go after king pins. But I used to do a lot of community work. And getting into the community you really get to see face-to-face what it is, the drug involvement is doing to the families.

What stresses me the most is as one is chasing drugs what are they doing to the children that they have left behind. And that is probably the single most motivating factor I have is trying to get these families back together. Because the social welfare costs for us to do nothing or to do a job poorly is devastating on the generations to come. We have generational uses, addicts, poverty. And there has to be an end to that. If I can get our folks off of these drugs they become reunited with their families. For one Drug Court defendant is now running the PTA, is the coach of a little league, and has—is raising their children. Is that not worth all the money in the world.

Ms. ROBINSON. Congressman, I would like to address that also. I can tell you where it first impacted me most significantly. And that was when I was working in the prisons. And I started off as a correctional counselor and I worked on the weekends. And what I saw was exactly what Judge Weitzman said. I saw the faces of the families that were impacted. I saw generations of families that were incarcerated in the facility. You had the fathers, you had the sons, you had the grandsons. And you had a whole cast of children that were fatherless, that had no male role models that could potentially help them to break the cycle. And then it became to me a mission to want to at some point impact the population significantly enough so that I would be in a position to help with policies that would impact the population. And at some point, put some closure to the addiction process.

Now that is a tall order. Because in order to do this it has to be a systematic approach. And one of the things that HIDTA tries to do is assist these programs in building infrastructure. Because the infrastructure is important. You have to have collaboration and communication among the agencies. If the Drug Courts and HIDTA and Break the Cycle are managing a common client and commu-

nicating progress on this client and holding this person accountable, then you give them an opportunity to stop the behavior. Because that is the first thing that you want them to do. You want them to stop using the drugs. You want them to stop committing the crimes. Then you want to address the problems that brought them to the system.

Now sometimes you are not able to do all of that. But if you can at least get them to the point where they stop committing crimes, using drugs, and become productive tax payers, with continued wraparound services you give this opportunity, this person a better opportunity to reintegrate successfully back into the community. And that is what we have got to do with these folks.

They stay incarcerated for years on end, some of them. But inevitably they have got to come out. And once they come out we have got to be able to address their needs from a systems perspective. And systems can no longer function as single entities. We have a tremendous demand for services. I mean, we are funding programs, like I said, in 12 jurisdictions. But we could probably serve every locality up and down the east coast and still not begin to address the needs for services.

So we have to become smarter in the way that we use the resources that we have available to us. And make sure that when we are providing these services that it is the appropriate level of service for that individual. Because drug use is a continuum.

You have offenders who have been in the system for only short periods of time. They do not need the same level of structure, same level of supervision as someone as Judge Weitzman was speaking of who has had an addiction and criminality for 20 or 30 years. So the system needs to respond to that particular individual's needs and address those needs at that level. And all of it again takes collaboration. All of it takes coordination. And all of it requires that we are compassionate about the population that we serve.

Mr. CUMMINGS. Mr. Chairman, when the Drug Czar was here 2 weeks ago, one of the interesting things that, you know, that we observed is that he had a chance to talk to 12 people from the Tuerk House and they will be testifying shortly. But at least three of the people said that they began their drug habits when they were 11 or 12 years old. And so these are people who are like probably in their thirties.

So that is kind of scary. And I would imagine the kind of environment, when you are talking about generations to come, you know, it seems as if we have no other incentive, you know, when you see little kids as I see going into elementary school, playing hop-scotch and hide-and-go-seek in the kindergarten, and the thought that there is a detention center which has just been built that I am sure will hold at least 1,000 children, and know that detention center is being built, has been built for the very children that you talk about, that is rather frightening. It really is. Thank you, Mr. Chairman.

Mr. SOUDER. Thank you. Judge Weitzman, I wanted to just ask you a couple of followup questions on your screening process. Is it for the long-term chronic addicts, is it voluntary to be in the program and they can withdrawal?

Judge WEITZMAN. Once they are in, they are mine.

Mr. SOUDER. In other words, if they—unless you kick them out they cannot voluntarily withdrawal if it is near the end of their term?

Judge WEITZMAN. I will not let them. Once they volunteer to get in the program they are my captives. And I am going to hold on to them until they absolutely give me no alternative but to violate them.

Mr. SOUDER. Because I thought under the law they are allowed to withdrawal if they are near the end of their term. In other words, if it is the intent of the program was voluntary. I understand that the ideal is to keep them in.

Judge WEITZMAN. Well, when we run out of probationary time and they have not successfully graduated then it will be their choice whether they want us to extend it or whether we will just go probation. But a few get there. They are either terminated out or they are graduates. So we do have a group in that category.

Mr. SOUDER. And that for the followup when you have the wraparound services that do that continue after the period they are in Drug Court and that is also voluntary?

Judge WEITZMAN. Yes. It is voluntary.

Mr. SOUDER. What percentage of your people that you have worked with continue in those services for, say, 2 years and how long have you had the program?

Judge WEITZMAN. I have not done a study on the longevity of the graduates in aftercare. We have an aftercare program that is set up for them that usually begins while they are still under supervision for us. And then continues, hopefully, and throughout. Our recidivism study suggests that they are still doing very well. So they must be maintaining good aftercare plans. Additionally, we have our support group. And some of them come back and assist us with that.

Mr. SOUDER. It has been a real struggle, one of my good friends from college, in fact, we ran in the student government election together. He was my vice-Presidential candidate. He was democrat and I was a republican. He is now the judge for our Drug Court in Fort Wayne. It was one of the first ones that they established, I don't know, it is probably getting close to 8, 10 years ago. And I have gone to the graduations of the different people from the program.

But it is a real battle. Because that is what I was mentioning earlier, the expectations sometimes are greater than can be done because these people are struggling with a lot of issues in their lives, and you try to do the best you can to——

Judge WEITZMAN. Yeah. I can clean the drugs out of the system. It is changing the behavior which is a struggle. It is getting them to understand that there are other ways of approaching their lives. And that is why the church mentoring program that we have, I think, is critical. By the way, I think the myth of the magic bullet here is spirituality. I find that at least with our group that those who have a spiritual connection, of course, with everything else that we are providing, do much better. And so if I am able to provide different tools through meditation, through support groups, through the church group, then we can enhance their success.

Mr. SOUDER. I am not overly enthusiastic about the potential for tremendous success out of Drug Court. But if it does not, the question is what else would. Because it has all the earmarks of the only things that absolutely can work. I mean, these are chronic people who have a drug problem. Yet they are voluntarily choosing to go into the program.

Judge WEITZMAN. That is——

Mr. SOUDER. Yes, it is a carrot and stick. But that is No. 1 is that somebody voluntarily choose to try to address something. So we have already done that. The second thing is you have got wraparound services with it. You have a judge who is checking with them regularly. You are doing the drug testing with it. You are holding them accountable. If this does not work, it is not like we have another option here.

So just because I say I have concerns about how well it will work does not mean that it won't achieve success. But I do not see how anything else can work better. Because you have all the combination of different issues.

Judge WEITZMAN. In my lengthy judicial career, which is no more than a decade, I have sat in regular criminal courts and drugs courts, and I must tell you that I find that this is the most worthwhile thing I have done in my career. And that, no, we do not have total success. This population is just too tough. But we are by far succeeding better than the normal, than the norm.

So I do not know what the magic potion is to get everyone to succeed. I do not think there is such a thing. Because people are at different levels at different times. But I am convinced that a holistic, coordinated approach greatly enhances the opportunities for success.

Ms. ROBINSON. And, Congressman Souder, also there are different points of intervention for this population. And though Drug Court may be a particular point in intervention continuum, there is also services available for this population in jail, in prison. And that is where they are the most captive audience.

If we are providing services appropriate to their need within the confines of the institution, then we are also addressing this problem from that particular perspective. And once they parole out, then you will have another point of intervention. And that is the supervision part in terms of parole and probation. And that is one that HIDTA addresses.

So and then there is the other point that I think no one really has mentioned since I have been here, and that is to prevent the prevention piece. So we have got to address this problem from a multi-task perspective. We cannot just look to any one, as Judge Weitzman said, magic bullet to address it. We have got to put resources to intervene at different points with this population, with the type of services that they need so that we are addressing it everywhere they are.

So that the juvenile facility that you mentioned is going to decrease in population. Because we have got funds that are available for preventing. If we can get these kids to recognize that they do not want to end up where their parents have, where their uncles, their mothers, their cousins and brothers have. Then we are doing

a tremendous job to impact the future level of service across the entire continuum.

You are talking about medical services. You are talking about educationally. You are talking about the entire gamut of the life experience for that juvenile You can arrest him right then, right there with the proper level of services provided right where they are.

Mr. SOUDER. In your HIDTA you have 43 different initiatives. And 12 in the Washington/Baltimore HIDTA are treatment and three are prevention. Do you know what the approximate dollar is that is given to treatment?

Ms. ROBINSON. Sure. $4.5 million to treatment. And I think it is about $300,000 or $400,000 to prevention.

Mr. SOUDER. And that is out of what size budget?

Ms. ROBINSON. I believe it was $11.2 million.

Mr. SOUDER. Do you know how that compares to other HIDTA's? Because most, I think only five HIDTA's are allowed to do treatment.

Ms. ROBINSON. Well, from my last understanding it was only one other that specifically funded treatment in the manner, or similar manner, that we do in Washington/Baltimore. Washington/Baltimore allows the jurisdiction to actually fund treatment that the continuum of services from residential, to intensive outpatient, to transitional living.

Whereas the other HIDTA, which is in Seattle, provides prevention services for the lion's share of their money. And also provides supplemental funding for the Drug Court. So they have approached it from a different perspective than Washington/Baltimore HIDTA has.

Now the other HIDTA that you mentioned may be providing money for DARE Programs, which are prevention programs.

Mr. SOUDER. Do you target drug traffickers in your prevention and treatment in particular, or do you target more users?

Ms. ROBINSON. We are targeting the—it depends on the jurisdictions. One of the great things about HIDTA dollars is that we allow them the flexibility to use the funds in the manner that is most expeditious for their particular locality. So some of them are targeting traffickers.

But the majority of them are actually targeting the hard-core substance abusing offender population. And those are the ones that are continuing to commit crimes in the communities and are continuing to use drugs at a prevailing rate on a daily basis.

Mr. SOUDER. But do you distinguish whether they are trafficking as opposed to large uses?

Ms. ROBINSON. Yes. And the interventions that are utilizing those individuals in those programs, they do. The mentality of that type of offender is different than a street user. So you have got to intervene again, as I mentioned earlier, at the level where they are. You cannot—there is no really such one thing as one-size-fits-all treatment. That everybody can be put in the same kind of treatment and you expect that the outcomes for that individual are going work. Because it does not.

Those who are traffickers are persuaded by the lifestyle. They want the fast money, they want all of the material trappings. So

they are not interested so much in the personal usage, although some of them are. But most of them want a piece of the pie. And they do not want to use the legal means to gain it.

Mr. SOUDER. We are looking, this committee has oversight over the Drug Czar, actually authorizing and oversight. And we are looking at the HIDTA's in the reauthorization because one of the problems we have in the Federal Government is that when there is kind of consensus, everybody moves toward consensus and all of a sudden we are paying three to five different grant structures to do the same thing.

That earlier Lieutenant Governor referred to the state efforts on drug and alcohol like we have in Indiana where we fund the Governor's office to reach out to coordinate community efforts on prevention and treatment. And elsewhere we have treatment dollars that go in toward treatment. We have Drug Courts dollars that are going directly to that. We now have, we have really through our subcommittee, boosted up the authorized dollars and the appropriating dollars are following for community anti-drug efforts. And everybody is coordinating the general effort.

The HIDTA program which is probably, it has evolved for past intentions of the HIDTA program and the question now, how do we change it. It is almost like every state is developing a coordinate effort through their HIDTA which is what you referred to as coordinating among groups, which was not the intent of a HIDTA. The HIDTA's intent was to be for where the trafficking was going through to focus on the trafficking per say. That is not to say that the goals are not really good. We met with the Seattle people, too, as well as Detroit where other, and other cities where the HIDTA's are trying to address it. But we have got to sort through not a change necessarily in how a community is approaching it, or even the number of dollars, but that the dollars are going toward what they were intended to go for. Maybe we reduce the dollars for HIDTA's and put more into treatment and into a different community infrastructure. Target the HIDTA's back more what they originally intended to do, which was to pick the highest drug trafficking areas and zero in on breaking up the networks. That is what we are trying to work through.

And that was beyond my question. And we will be talking to you more directly because you are the primary, I mean, you are basically saying close to 40 percent of your funding has gone to treatment. Certainly, 40 to treatment and prevention. Seattle is the most far along with that. Clearly, trying to figure out how to coordinate that with the dollars we are putting into the states and the big boost up in the community groups. We need to make sure because that was one of our questions. Excuse me, I am really battling a cold. To the community organizations was how do we avoid paying for coordinators three times. How do we make sure that the maximum dollars are actually getting to the street level. And it is one of the things we will be working through. Do you have any other?

Mr. CUMMINGS. Yeah, just two things. Ms. Robins, just piggyback on what the chairman just said. The President's budget cuts HIDTA by $20 million. And I think we have checked and it does appear that our HIDTA here will be affected this time. But that

is something that we really do have to deal with. Because I can see what will happen. They will look at this HIDTA and say, OK, what he just said. Where can we make these cuts. And the cuts will come in those programs that are unique, like this one.

The problem with that is is that the funds that are now being used out of the HIDTA piece for drug treatment may not ever get back to those individuals who need the treatment. And that is a real problem. The only other thing I wanted to say, I want to thank both of you, first of all, for being with us. And, Judge, you know, as you were talking I was saying to myself that, you know, it is so said in this country that so often people do not get to the—you all see the faces, both of you. You see the faces of these folks and reality. And there is just a gap so often with the Congress and the policymakers everywhere. Sometimes there is a big gap between the reality and the policies that we are making, you know.

And when you said, Judge, that, you know, out of all the things you do as a judge, this is the most meaningful thing that you do, whatever you said. I mean, I wish, you know, the whole Congress could hear that, you know. Because I mean, that is the bottom line. I mean, apparently this is something that is effective. And I am sure you feel the same way, Ms. Robinson. Something that is effective and it works.

And this is the first time I have heard testimony, and we have heard a lot of testimony over the years, where there is actually talk about future generations. This is the first time. And we all know it. But it is the first time I have heard it talked about in a hearing setting. And so, you know, we—and perhaps that kind of focus is what will bring policymakers more in line with what is actually happening in our neighborhoods.

I think that we have made a tremendous, made tremendous progress with regard to our community anti-drug program where we give community associations dollars to help them fight drugs. I mean, I think we have—that is more in line with what is happening out there. I think the drug treatment, there is still more that needs to be done. Unfortunately, we have limited resources.

And one of the things that I am sure the chairman agrees with, and that is that all of these programs because there is now such a great competition for the dollars, have to able to show effectiveness and efficiency. I mean, it is—that is just real. And one of the things that we have been looking at and the Drug Czar talked about, not only when he was at the Tuerk House, but also when he appeared before our committee to lay out his plans, was that he really wants to see the programs are effective. And those programs that are not effective are going to fall by the wayside.

And so, you know, I think that we have just have to keep all that in mind. And you all have to keep letting people know what you know works. And thank you very much.

Judge WEITZMAN. Congressman, to convince you of the effectiveness, come to the graduation, which just happens to be tomorrow. You are all welcome to join us.

Ms. ROBINSON. And one final comment also, Congressman Souder, although I understand the need to separate and garner our resources expeditiously, again, I would want you to keep in mind that we have to approach this from a three-prong perspective.

Although the HIDTA's may have initially been designated to just address the trafficking, the outcomes that the treatment and prevention initiatives have been able to produce since we have been involved in that HIDTA far, far exceed I think some of the outcomes that you would see with some of the trafficking initiatives. Because we are able to put quantitative measures on what we do.

We are not specifically just looking at—well, we are specifically looking at the numbers of people that we are impacting, and the social costs for those offenders in those communities. So I think that what we are doing is truly outstanding. And I just want to leave with that.

Mr. SOUDER. Well, thank you for your work. We appreciate all your efforts to help the kids and families and the communities that are so devastated by the drug and alcohol abuse. And we appreciate you coming today and giving your testimony.

Ms. ROBINSON. Thank you.

Mr. SOUDER. If the third panel could come forward. Dr. Beilenson, Dr. Johnson, Mr. Hickey and Ms. Seward. As soon as you all get comfortable and seated I am going to have you stand again. So just—as you may have heard me say earlier, we are an oversight committee so we swear in all of our witnesses.

[Witnesses sworn.]

Mr. SOUDER. Let the record show that all the witnesses responded in the affirmative. Dr. Beilenson, you are recognized for 5 minutes.

STATEMENT OF PETER BEILENSON, M.D., M.P.H., BALTIMORE CITY HEALTH COMMISSIONER AND CHAIRMAN OF THE BOARD OF DIRECTORS OF BALTIMORE SUBSTANCE ABUSE SYSTEMS [BSAS], INC.

Dr. BEILENSON. Thank you, Mr. Chairman. And Congressman Cummings, thank you for having the folks come up to hear about Baltimore. I do not want to reiterate too much because people have been talking about our successes and the mayor and Lieutenant Governor and the police commissioner talked about some of what I was going to talk about. I want to touch on two things. One is accountability, the other is effectiveness.

I have just passed out something, this template that you all should have. You have heard about DrugStat and Comstat. This is what we use. We used outcome measures. Not how many people are seen but actual outcomes in our treatment programs to show their effectiveness, just as Congressman Cummings was talking about. Because we want to know—there is competition for dollars and we want to know which programs work the best. Every Friday myself and two of our staff folks who do the stat analysis, along with a lot of people from Baltimore Substance Abuse Systems, including Bonnie Sieple, our president, meet with the directors of the treatment programs. We have a hammer over them because we fund them all. They must show up. And have usually ten. We do it by modality. So for example, this sheet is the method on treatment programs, and this is actually from about 9 months ago.

But we hold them accountable for meeting benchmarks. These benchmarks were set and suggested by a national scientific advisory committee. They are based on national data. And all the

benchmarks were set above national averages. So we are holding our treatment programs to a higher standards of the country's. And it is very simple. We go around, if there is someone who is an outlier, we ask them, depending on my mood, either the outliers on the positive side or the negative side, why are you doing so well compared to other programs, or what is the problem here. And they must respond. If they cannot respond with a reasonable explanation they have 2 weeks to respond in writing.

If their numbers consistently do not meet the benchmarks they get decreased funding and eventually defunded. So we are truly, truly doing accountable-based management, or whatever you want to call it.

As I think Judge Weitzman or Lt. Governor Townsend was saying, the length of stay in treatment is very important. So we do look at retention rates. And at least 3 months retained in treatment are a good marker for how effective treatment is going to be. So that is one of the things we look at. We also look at arrest during treatment. There is a typo at the bottom on the arrest column there which is toward the middle that says 70 percent is the benchmark. Actually it is a 10-percent or less getting arrested during treatment.

We also look at employment statistics. How many are employed at admission and how they did at discharge.

And we look at housing statistics as well. Some of those are not on there, they are on the secondary sheet.

What kinds of things do we do? Well, here is an example of how DrugStat actually works. Mr. Souder, since he is the majority I will let him do better, if you do not mind, Congressman Cummings. The chairman's, Mr. Souder's residential treatment program. This is an actual example of what has happened in DrugStat, only not Souder and Cummings, of course.

Mr. Souder's treatment program and Mr. Cummings treatment program both have very similar clinical outcomes. But Mr. Souder's had a much better employment increase over admission than Mr. Cummings. So we asked Mr. Souder, what are you doing. Well, they all had the similar wraparound services. And I will maybe have time to talk about enhanced services. You cannot treat treatment, you cannot treat drug abuse in a vacuum. As people have been saying over and over a slot alone does not do it. You got to have wraparound services. We have mental health services, medical services, housing, jobs, etc. All those services are at many of our treatment programs, including childcare. But in this case, Mr. Cummings program was sending people offsight to a job training program, who then maybe did some placement. But, of course, many of our folks do not have transportation. Every time you have to go offsight it makes it harder to get some place.

Mr. Souder's program, again this is an actual example, had developed a pipeline to three different employers who were willing to take a flyer initially on Mr. Souder's statement that this guy who was a former incarceree, who has been clean now for 4 months, he is a good guy, take a flyer on him. Hired him and now there is a good pipeline. So what we have done is now initially recommended in all of our contracts with our treatment providers that they have these direct pipelines, actual employers who will take their clients,

and similarly requiring them in contracts. Not that every client has to go to these employers. But at least there are some pipelines.

Those are some of the things, the lessons that we have learned from DrugStat and that come out from getting everybody to meet. Each modality meets about every 4 weeks. But every Friday we have these meetings. And we have driven the system forward. That has resulted, this accountability has resulted in the effectiveness that you have heard from the smart, what is it called, Steps for Success, that Jeannette is going to talk about a little bit more.

To show you some of the global effects, these graphs. The yellow bars are the number of treatment spots. They have increased over the last couple of years. The red line is the violent crimes that you heard about from the commissioner and the mayor. The blue line is the drug related emergency room visits. 2001 is not out yet. That just shows some direct correlations that as you increase treatment and make it more effective and have enhanced services, you reduce the crime and drug related emergency room visits.

Let me—the only other one I am going to touch on here of the graphs, because I do not have too much time, is that the cost of, and Jeannette Johnson is going to talk a lot more about this, for—you heard briefly that $9 million that was pledged in the Governor's budget would serve about 4,000 more clients. What does that mean in actual people terms? It means approximately 700,000 fewer days of heroin use in Baltimore City. It means about 240,000 fewer days of crime being committed in Baltimore City. That is how important just treating 4,000 folks are.

And the important point to make is that this investment is not, it is not one of these long-term investments. Although I am hugely in favor of reducing tobacco usage, you will see 20 years down the road you will see less cancer. Within a year, actually within a month, as you will hear shortly, drug treatment dollars start paying dividends in terms of reduced crime, increased employment, getting back with their families. I guess I have to end.

But I would be happy to give you some personal evidence that this works and more from the city's perspective when you have questions. Thank you.

[The prepared statement of Dr. Beilenson follows:]

Statements of Peter L. Beilenson, MD, MPH
Baltimore City Health Commissioner
Before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Tuesday, March 5, 2002

Thank you Chairman Souder and subcommittee members, for the opportunity to testify on the status of drug addiction and our corresponding treatment efforts in Baltimore City.

Three years ago, Baltimore City and the Maryland General Assembly began a partnership to substantially increase investment in drug treatment. This commitment, if fulfilled this year with the final $9 million allotment, would increase funding by $25 million for Baltimore City's treatment system. This investment has propelled the City's drug treatment system to its current position as the premier in the nation, with success rates that far exceed those of cities of similar size and demographics.

Baltimore's publicly funded treatment system is managed by Baltimore Substance Abuse Systems (BSAS), a quasi-public agency overseen by the Baltimore City Health Department (BCHD). BSAS distributes approximately $26 million in State and Federal funds to 35 substance abuse treatment programs.

Current funding levels provide for over 7,700 drug treatment slots throughout the City, which serve approximately 22,000 individuals. Heroin is the primary 'drug of choice' among the estimated 50 - 60,000 addicted residents in Baltimore City. The majority of Baltimore City's substance abusers are between 31 and 50 years of age. Between July 2000 and June 2001, 66% of drug treatment center clients were uninsured, 33% were unemployed, and 34% had been arrested at least once in the 24 months prior to treatment.

To promote accountability and measure the success of its treatment system, Baltimore City has implemented the first-of-its-kind, data-driven evaluation of its publicly funded treatment providers. *DrugStat*, now in its second year, is a forum for cooperation and collaboration among treatment providers and has shown improvements in treatment and socioeconomic outcomes since its implementation.

The effectiveness of drug treatment is undisputed, and we know that paired with smart law enforcement strategies, drug treatment reduces crime. A recently released (Jan.2002) independent evaluation of Baltimore's drug treatment programs, shows significant drops in crime and drug abuse one year after initiation of treatment. The study, Steps to Success: Baltimore Drug and Alcohol Treatment Outcomes Study, found that within one month after entering treatment, use of alcohol, cocaine and heroin each fell by more than 60 percent. One year later, the effects of treatment were still evident: Heroin use dropped 69 percent, cocaine use 48 percent, and criminal activity dropped 64 percent.

Studies like *Steps to Success* prove that drug treatment provides a generous return on investment of public dollars, both financially and in the overall improvement of public health and safety. We are more confident than ever in the effectiveness of drug treatment. As a result, we must redouble our efforts to provide drug treatment for all who need it.

PB – Graphs or no graphs?

Mr. SOUDER. Thank you. Dr. Johnson.

STATEMENT OF JEANNETTE JOHNSON, PH.D., PROFESSOR, SCHOOL OF SOCIAL WORK, UNIVERSITY OF BUFFALO

Dr. JOHNSON. Thank you very much for having me speak today on behalf of the effectiveness of substance abuse treatment. There are generally two major questions that are always asked of history, and that is, what did we know and when did we know it. And the history of the systematic efforts to identify and empirically validate treatments is a long one. And for the past several decades we have known a great deal about the effectiveness of substance abuse treatment.

From several federally funded nationally surveys and studies we have been able to show that when substance abusers stay in treatment they reduce their incidence of substance use, they reduce their involvement in criminal activity, and they increase their involvement in legal and normal day-to-day activities.

The city of Baltimore has once again provided strong evidence that substance abuse treatment works to benefit the individual and the communities in which they live. In an unprecedented 3 year study, Baltimore has not only shown that substance abuse treatment reduces heroin use, reduces alcohol use, dramatically reduces cocaine use, and reduces crime, but the Baltimore study has shown that the substance abuse treatment also helps the non substance-abusing resident. Because substance abuse treatment decreases the frequency in which substance abusers commit crimes for profit.

Participants in methadone treatment, for example, decrease their illegal income from $480 per month prior to entering treatment to just $101 per month 1 year after entering treatment. And although participants remained at very low income levels, we found that they worked more and earned more legal income 1 year after entering treatment than they had before treatment began.

Substance abuse treatment also helps America's public health. Because the Baltimore study showed that methadone treatment decreases risky behaviors, such as going to shooting galleries, reducing the risk of transmitting or contracting HIV, hepatitis B or C, and other sexually transmitted diseases. Baltimore substance abuse treatment study shows that after 12 months the study participants in study abuse treatment reduce their illegal income by a total of $3.2 million. And reduce their total number of days of heroin use alone by 164,000 days.

As members of families and communities, we know that we need substance abuse treatment. The National Institute on Alcohol and Alcoholism conducted an epidemiological survey and showed that 48 percent of all Americans are related to somebody with an alcohol problem. As healthcare professionals we see the social and cultural disintegration results from untreated substance abuse disorders. This disintegration travels from generation to generation. By not treating substance abuse now you almost guarantee the fate of future generations of the children of substance abusers to another life of drugs, crime and social, cultural and familial disintegration.

The data on the transmission of alcohol and drug abuse from parent to child is fairly clear. We know, for example, that sons of

alcoholics are more likely to become alcoholic than the sons of non alcoholics.

As scientists we are committed to evidence and not opinion. It is not merely our opinion that substance abuse treatment works for the benefits of all Americans. It is decades of accumulated evidence from federally funded surveys and studies that shows the effectiveness of treatment.

Now the city of Baltimore has provided the strongest evidence to date. This is not our opinion, this is not our guess, and it is not our political view. The data shows that substance abuse treatment really works.

In conclusion, I can answer two of those historical questions. What did we know? We know that substance abuse treatment reduces heroin and cocaine use. We know that substance abuse treatment reduces drinking. We know that substance abuse treatment reduces criminal activity. We know that substance abuse treatment reduces the risky behaviors related to HIV.

And when did we know it? We have known it for a long time. But now with the Baltimore study we know it again. We now have the strongest evidence to date that shows us that we know how to stop the demand for drugs. We know how to treat alcohol and drug addiction. We can do it effectively. People shouldn't have to wait or be turned away.

And in conclusion, substance abuse is a problem we know how to treat. And we save money, children, and countless lives by doing so.

[The prepared statement of Dr. Johnson follows:]

Testimony of Jeannette L. Johnson, Ph.D.
Written Remarks

The Baltimore Drug and Alcohol Treatment Outcomes Study is the largest and most rigorously conducted drug treatment outcomes study that focuses on a single city. It is one of the key components of Baltimore's strategy to rigorously evaluate and continuously improve the public treatment system, as it expands to meet the needs of the city's uninsured citizens. Overall, the study found a marked reduction in drug and alcohol use, crime, risky health behaviors and depression among participants who voluntarily entered publicly funded outpatient drug and alcohol programs in Baltimore City. This comprehensive study is the result of an unprecedented collaboration among the University of Maryland (Jeannette Johnson, Principal Investigator, and Robert Schwartz, Co-Investigator), Johns Hopkins University (Robert Brooner, Co-Investigator) and Morgan State University (Ashraf Ahmed, Co-Investigator), with the cooperation of 16 treatment programs and nearly 1,000 treatment participants. Baltimore Substance Abuse Systems, the agency responsible for publicly funded treatment in the city, funded the study.

The data included in the analyses reported here represent findings from 991 uninsured Baltimore City residents who voluntarily entered outpatient drug and alcohol treatment through 16 publicly funded programs from 1998-1999. Two kinds of programs are included in the study, those that treat heroin addicted individuals with methadone and counseling and those that treat alcohol, heroin, cocaine and other drug users with counseling only. All study participants provided informed consent and completed an initial assessment; the 991 reported in detail here also returned for at least one treatment session. Since this subset of 991 participants may have received as few as one treatment session, treatment outcomes represent conservative estimates of the benefits of treatment. In keeping with the methodology of earlier national studies, participants' self-reported behaviors at treatment entry were compared with those reported at one, six, and 12 months thereafter. While self-reports under confidential research conditions have been shown to be generally valid, investigators also examined objective measures of drug use and crime, including urine drug tests and official arrest and imprisonment records.

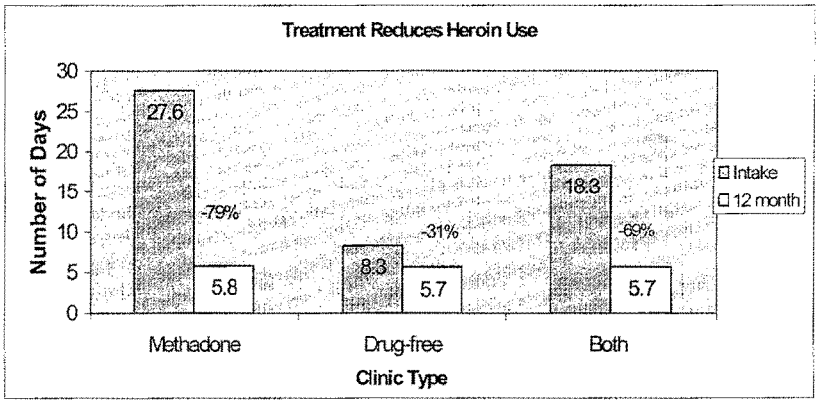
The average participant in the Baltimore Drug and Alcohol Treatment Outcomes Study was 37 years old. Nearly 50 percent were women and 85 percent were African-American. Three-quarters of the clients treated were unemployed and had an average annual income well below the poverty line, indicating that the public treatment system is fulfilling its mission to serve individuals who otherwise could not afford to enter drug treatment. On average, participants reported using heroin on 18 of the 30 days prior to entering treatment entry, using cocaine on six of 30 days and drinking to intoxication on four of 30 days. Given the difficulty women often face in entering treatment, the large proportion of women who participated in the study indicates that stigma surrounding substance abuse is not an insurmountable barrier to seeking treatment.

Reduction in Drug Use

Overall drug use among participants was significantly reduced as early as 30 days after treatment and remained below the pre-treatment levels at 12 months. These reductions in drug use are consistent with those found in large multi-city trials that have been conducted over the past 20 years. Urine drug testing confirmed over 70 percent of the self-reports of cocaine abstinence and over 75 percent of the self-reports of heroin abstinence. These high rates of agreement between self-reported drug use and urine results are also consistent with earlier studies and support the accuracy of self-report data.
Heroin Use

Heroin use declined at statistically significant rates for all treatment participants. Over the first 30 days of treatment, heroin use declined by 72 percent. This improvement was sustained at 12 months after intake (69 percent). Clients enrolled in methadone programs used heroin three times more frequently in the month prior to intake than clients enrolled in drug-free treatment. The decline in heroin use was greater for those enrolled in methadone programs at the one, six and 12 month follow-up interviews than for those enrolled in drug-free treatment.

Despite the widely recognized difficulty associated with discontinuing heroin use, drug treatment was associated with a remarkable and sustained reduction in heroin use up to one year from treatment entry. Heroin use contributes significantly to overdose death, emergency room visits and associated infections such as hepatitis B and C and HIV. The proven effectiveness of heroin treatment underscores the need for treatment capacity in those programs.

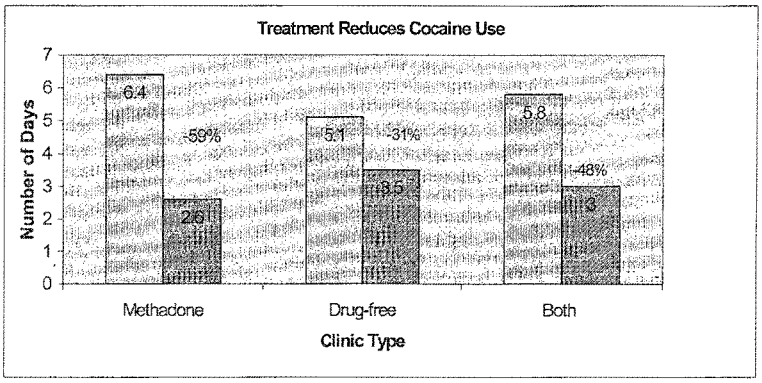


This Figure shows the average number of days clients used heroin within the past 30 days prior to intake assessment and 12 months after initiating treatment services.

Cocaine Use

There was a statistically significant decrease in participants' cocaine use over the 12 months following treatment entry. Cocaine use declined by 64 percent at 30 days from intake, 43 percent at six months and 48 percent at 12 months. Clients enrolled in methadone treatment had a higher baseline level of cocaine use (6.4 days) than those enrolled in drug-free treatment (5.1 days). There was a greater decrease in cocaine use among participants in drug-free programs compared to participants in methadone programs over the first 30 days of treatment (70 percent vs. 59 percent). Although both groups maintain improvement at six and 12 months, cocaine use declined at a lower rate among participants in drug-free treatments than among those in methadone clinics.

The erosion in improvement for drug-free clients is probably due to the higher dropout rate seen in these clinics compared to methadone programs. Treatment retention has repeatedly been linked to improved outcomes. Efforts by Baltimore to improve treatment retention, such as its Drug Stat Program in which outcomes are reviewed monthly by the treatment program directors, BSAS staff and the Health Commissioner to hold programs accountable and improve performance, are therefore critical to increased success.

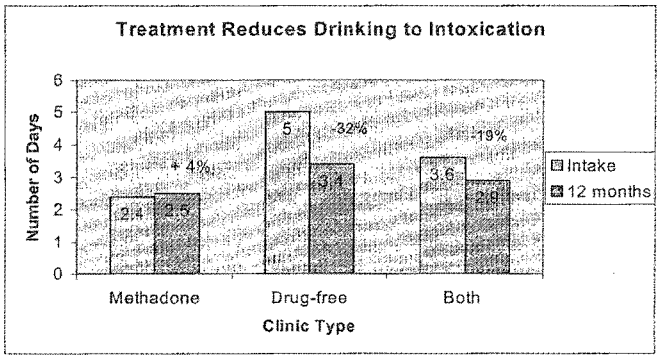


This figure shows the average number of days clients used cocaine within the 30 days prior to intake assessment and the 12 months after initiating treatment services.

Reduction in Alcohol Use

The study finds a statistically significant reduction in overall alcohol use during the 12 months following treatment entry. The average number of days of drinking to intoxication declined by 64 percent at one month after intake and 34 percent at six months. By 12 months after intake, participants reported drinking to intoxication 19

percent less than they had at intake. These findings indicate that treatment significantly reduces heavy drinking over the first month of treatment and, though the improvement attenuates over time, heavy drinking remains considerably less frequent (19 percent) even after one full year after the start of treatment. Participants treated in drug-free programs had greater alcohol problems at baseline and showed greater and more sustained improvement than those participants enrolled in methadone treatment.

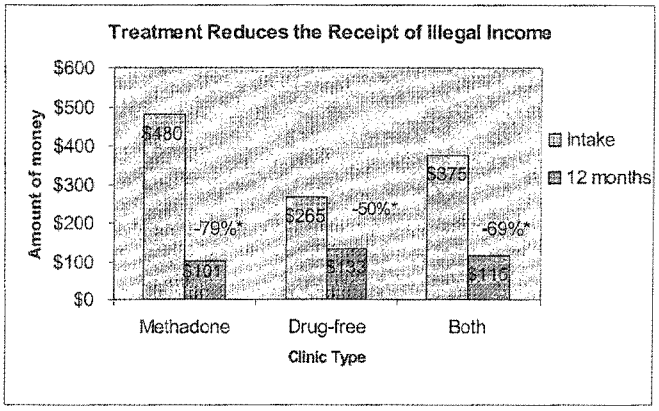


This figure shows the average number of days clients drank to intoxication within the 30 days prior to intake assessment and the 12 months after initiating treatment services.

Reduction in Crime

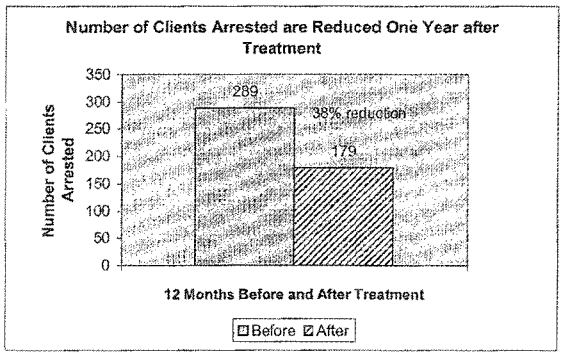
Researchers and law enforcement experts have linked the illegal nature of behaviors associated with drug addiction to crime. The legal problems of study participants improved significantly over the 12-month study follow up period, confirming previous national studies that indicate that addiction-related crime decreases significantly as a result of effective treatment.

Participants engaged in illegal activities 64 percent less at 12 months after treatment entry. Participants also significantly reduced the amount of illegal income they received by 77 percent at one month after treatment entry. At 12 months after treatment entry, the amount of illegal income remained low at 69 percent below levels at the start of treatment. This decrease occurred among participants in both kinds of treatment, although the methadone participants started at a higher level of illicit income and improved more markedly than the drug-free clients. The other self-reported drops in crime days, illegal income and drug use all underscore the importance of drug treatment as a key part of Baltimore's crime reduction strategy.



This figure shows the amount of illegal income received by the clients in the 30 days prior to intake and the 12 months after initiating treatment services.

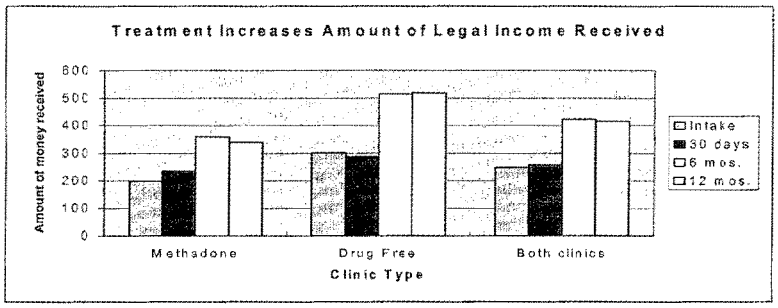
Official arrest records show a 38 percent decline in the number of treatment participants whose arrest led to an imprisonment in the 12 months prior to treatment (289 participants) compared to the 12 months after treatment entry (179 participants). These data must be considered preliminary, as there is often a time lag for sentencing, which results in an underreporting of the number of imprisonments during the follow-up period. Future reports, using additional data will update these preliminary findings.



The preliminary data in this figure are restricted to a subgroup of clients who were found guilty of crimes that led to imprisonment by the Division of Corrections.

Increased Earned Income

Treatment participants worked 52 percent more and earned 67 percent higher wages in the 30 days prior to the 12-month follow-up interview than they did in the 30 days prior to entering treatment. These improvements included "off the books" employment, which constitute an important source of income for marginalized populations. This informal labor market does not include illegal income but is characterized by a lack of health and other benefits, poor job stability and low pay. Though participants' income increased to an average of $415 per month, it remained considerably below the poverty level.



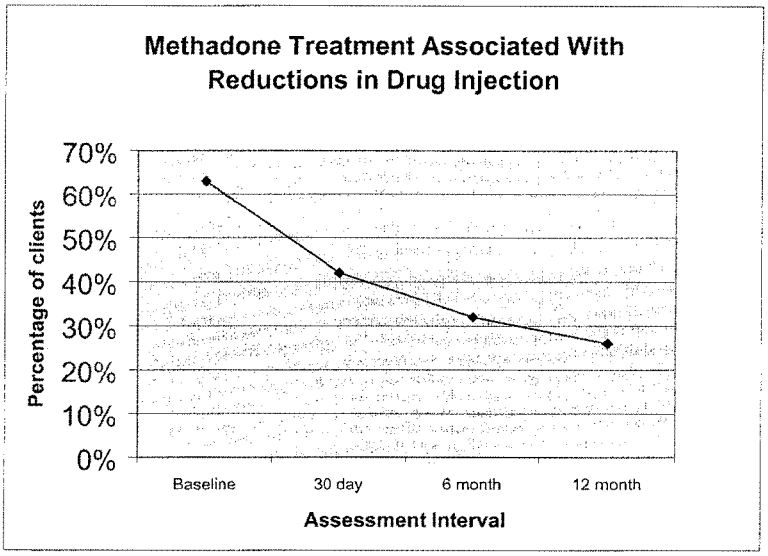
This figure shows the increase in the average amount of money earned within the past 30 days at each assessment period, separated by the type of clinic the client attended; then, both clinics are combined for an average of the clinics.

Decreased Depression

A substantial minority of people enrolling in drug and alcohol treatment had symptoms of depression at treatment entry. Study findings show a statistically significant decrease in depression scores across the study's follow-up intervals. Participants enrolled in methadone programs had more severe depression and more marked improvement than people treated in drug-free clinics. While many symptoms of depression improve with abstinence from drugs or alcohol, it is important to have anti-depressant medications and psychotherapy available for those clients whose depression does not spontaneously remit after drug and alcohol treatment alone.

Reduction in HIV Risk Behavior

Alcohol and drug dependence increases the risk of transmitting HIV, Hepatitis B and C and other sexually transmitted diseases through sharing injection equipment and unsafe sex. Study findings show a 59 percent reduction in drug injection among methadone clients at 12 months from the start of treatment. These robust reductions in drug injection reduce the risk of disease transmission.



This figure shows data from methadone clinics and is based on the response to the question, "Have you injected drugs in the past 30 days?" All time points cover the 30 days immediately preceding the evaluation.

Shooting galleries are buildings in which intravenous drug users congregate. They are a site of the spread of HIV, hepatitis and other sexually transmitted diseases through sharing of needles and other drug paraphernalia, as well as through trading sex for drugs. There was a statistically significant decline in the number of participants frequenting shooting galleries over the 12 months after entering treatment.

Benefits of Treatment- on-Demand

The benefits of treatment-on-demand for alcohol and drug dependent people can be measured by comparing participants' behaviors during the 30 days before they entered treatment with those reported in the first 30 days after entering treatment. Based on the average drop in drug use and crime in the first 30 days of treatment compared to the 30 days prior to treatment entry, treatment of an additional 1,000 people per year avoids: 164,000 days of heroin use, 45,600 days of cocaine use, 63,600 days of crime and $3.2 million in illegal income.

Negative Impacts on People and Society Resulting from Delays in the Onset of Treatment Services (for 1,000 people)

Behavioral Domain	30-Day Delay	6-Month Delay	12-Month Delay
Additional Drug Use			
Days of Heroin Use	13,700	82,200	164,400
Days of Cocaine Use	3,800	22,800	45,600
Additional Crime			
Days of Crime	5,300	31,800	63,600
Illegal Income	$267,850	$1,607,100	$3,214,200

Conclusions

The finding of Baltimore Drug and Alcohol Treatment Outcome Study are compelling as they confirm and build upon the results of other nationwide studies and upon documented trends in the past year in Baltimore (e.g., decrease in drug-related emergency room visits, overdose deaths and crime). Even after one year from treatment entry, participants significantly reduced their heroin, cocaine and alcohol use, decreased the number of crimes they committed, improved their psychological functioning, increased their legal income and reduced their risk of getting and transmitting life threatening diseases such as HIV and hepatitis. These findings support the efforts of the City of Baltimore and the State of Maryland to expand and improve the city's treatment system. Expanding the capacity of the public system will enable all city residents to have rapid access to high quality treatment services resulting in improved health and well-being for them, and their families and communities.

Mr. SOUDER. Thank you. Mr. Hickey.

STATEMENT OF JOHN HICKEY, DIRECTOR, TUERK HOUSE DRUG TREATMENT CENTER

Mr. HICKEY. Good morning. It's a pleasure to be here. It certainly is compared to going to the regular DrugStat meetings. I am John Hickey, Director of Quarterway Houses, Inc., which includes Tuerk House, the 76 bed, abstinence-based residential treatment center here in Baltimore.

While Tuerk House treats many people involved in the criminal justice system, I will be focusing my remarks today on two groups in particular. The first group is composed primarily of men referred by the Department of Parole and Probation. The second group is composed of women referred by Alternative Directions, a private agency funded by the Department of Corrections to facilitate the release of women from prisons and jails.

The experience with Parole and Probation has produced a rather dramatic outcome. Of the last 50 clients referred by the Department of Parole and Probation and admitted to Tuerk House, 44, 88 percent, have completed the 28-day residential program.

The second program, Alternative Directions, moves women from jails and prisons to the Tuerk House residential program, and then to continuing care in the Quarterway Outpatient Clinic. All the while Alternative Directions is providing case management and wraparound services. Last Friday, 11 women referred by Alternative Directions were included in a class of 38 men and women graduating from the outpatient clinic. Each of these women had to participate actively in the outpatient program and achieve a minimum of 7 months drug free in order to graduate.

It is clear that both of these criminal justice programs are very successful at identifying people involved in the criminal justice system who are in fact receptive to treatment. Because we cannot effectively identify those whose criminal behavior is the result of their addiction, and are in fact amenable to treatment, we would be well advised to divert drug dependent people from jails and prisons. And if they are already in jails and prisons, we need to get them out and into treatment. We cannot afford as a society to imprison those who would respond to treatment and become contributing members of society.

I must call to your attention, however, that the existing resources are not capable of treating all those in need. We provide a support group for people waiting for a treatment bed to become available in Tuerk House. Recently, there were 29 men in attendance. Since 70 percent of our residents are heroin dependent, the men in the holding group are at great risk every day that we simply release them to the street. We actually lose about 30 percent prior to admission. This is not a paper waiting list. This is a group of our fellow human beings with a life-threatening condition and we need to respond to their cries for help in a more expeditious manner.

I would like to call your attention to what I believe are three key treatment issues.

First, I would like to mention that while Tuerk House is abstinence-based, we use Buprenorphine for detoxification from heroin.

We know that people have stayed away from treatment in the past because they are afraid of withdrawal. Our experience is that Buprenorphine offers a substantial relief, reduces the fear, and increases admissions.

Next, I would like to point out that while we define alcoholism and addiction as chronic relapsing conditions, we provide abstinence-based treatment only in time limited models. Ultimately, everyone is discharged. I believe the universal practice of discharge is the most fundamental flaw in abstinence-based treatment in the United States today.

We have made a beginning to deal with this issue by establishing a peer support program at Tuerk House. Peer support is a self-help relapse prevention strategy for people that have received treatment. The key idea is to stay connected to the treatment agency and to stay connected to those who have had the benefit of treatment and are now striving to live in recovery.

Finally, it must be stated that a 28-day treatment program like Tuerk House is just the beginning of treatment. No one leaves Tuerk House without a referral to an outpatient program or halfway house. For many people, Tuerk House is essentially phase one of the Baltimore Substance Abuse Systems, Inc. continuing of care.

Thank you for inviting me to share with you this morning.

[The prepared statement of Mr. Hickey follows:]

Testimony of John E. Hickey, Ph.D.
Executive Director, Quarterway Houses, Inc.
House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Baltimore, Maryland, March 5, 2002

Good morning ladies and gentlemen. I am John Hickey Director of Quarterway Houses, Inc. which includes Tuerk House a 76-bed abstinence-based residential treatment center here in Baltimore.

While Tuerk House treats many people involved in the criminal justice system I will be focusing my remarks today on 2 groups in particular. The first group is made of mostly men referred by the Department of Parole and Probation. The second group is composed of women referred by Alternative Directions, a private agency funded by the Department of Corrections to facilitate the release of women from prisons and jails and to help them successfully transition back to the community.

The experience with Parole and Probation has produced a rather dramatic outcome. Of the 50 clients referred by the Department of Parole and Probation and admitted to Tuerk House over the past 6 months, 44 have completed the 28-day residential program for a completion rate of 88 percent.

While these residents may at first resent being at Tuerk House and resist the education that is presented, they ultimately become open to the message of recovery and the hope that can be found in abstinence-based treatment.

The second program Alternative Directions moves women from jails and prisons to the Tuerk House residential program and then to continuing care in the Quarterway Outpatient Clinic. During the entire process Alternative Directions provides case management services. Last Friday 11 women referred by Alternative Directions were included in a class of 38 people graduating from the outpatient clinic. Each of these women had to participate actively in the outpatient program and achieve a minimum of 7 months drug free in order to graduate. The overall completion rate for the 7-month program at Tuerk House for clients referred from Alternative Directions is about 60% and getting better as we provide a more effective service.

It is clear that both of these Criminal Justice Programs are very successful at identifying people involved in the criminal justice system who are in fact receptive to treatment. Because we can effectively identify those whose criminal behavior is the result of their addiction and are in fact amenable to treatment we would be well advised to divert drug dependent people from jails and prisons and, if they are already in jails and prisons, we need to get them out and into treatment. We can't

afford as a society to imprison those who would respond to treatment and become contributing members of the community.

I must call to your attention, however, that the existing resources are not capable of treating all those in need. We provide a support group to people waiting for a treatment bed to become available in Tuerk House. Recently there were 29 men in attendance. Since 70 percent of our residents are heroin dependent, the men in the holding group are at great risk every day that we simply release them to the street. We actually loose about 30 percent prior to admission. This is not a paper waiting list this is a group of our fellow human beings with a life threatening condition and we need to respond to their cries for help in a more expeditious manner.

I would like to call your attention to what I believe are 3 key treatment issues.

First I would like to mention that while Tuerk House is abstinence-based we use Buprenorphine for detoxification from Heroin. Funding needs to be available nationally to insure that no heroin dependent person avoids treatment because they are afraid of withdrawal. Our experience is that Buprenorphine offers substantial relief and reduces the fear.

Next I would like to point out that while we define alcoholism and addiction as chronic relapsing conditions we provide abstinence-based treatment only in time limited models. Whether it is a residential experience or outpatient treatment, whether it is 6 months or 1 year, the day finally comes when the patient is told, well we've given you the tools to survive and now all you have to do is work the program and you will be okay. Ultimately everyone is discharged. I believe the universal practice of discharge is the most fundamental flaw in abstinence-based treatment in the United States today.

We have made a beginning to deal with this issue by establishing a peer support program at Tuerk House. Peer Support is a self-help relapse prevention strategy for people that have received treatment. The key idea for our group is to stay connected to the agency that helped you and may need to help you again in the future, and to stay connected to those who have suffered from addiction, have experienced the benefits of treatment, and are now striving to live in recovery.

Finally it must be stated that a 28-day treatment program like Tuerk House is just the beginning of treatment. No one leaves Tuerk House without a referral to an outpatient program or a halfway house. Tuerk House is essentially phase one of what must be a long-term commitment to recovery by both the patient and the community.

Thank you

Mr. SOUDER. Thank you very much. Ms. Seward.

STATEMENT OF ELIZABETH SEWARD, GRADUATE AND PROGRAM COORDINATOR, TUERK HOUSE DRUG TREATMENT CENTER

Ms. SEWARD. Good afternoon. Thank you for allowing me to come to speak to you today. My name is Elizabeth Seward. I am a recovering addict and a graduate of the 28-day program and outpatient program at Tuerk House.

I will tell you briefly a little bit about my story. I began using drugs to fit in. I guess I began about 20, in my early 20's. And it started out as fun, you know. I was a functional addict, I considered myself a functional addict for a number of years. I worked as a factory worker and trained other workers on machinery. I know—a lot of us would be using drugs in the workplace, you know, alcohol, marijuana. And that is where I started.

And it kept me from understanding I was an addict. I did not know I was an addict at that time. At 39 I started sniffing cocaine, which led me to using crack. That crack devastated my life for 7 years.

In 1997 one of the worst things that happened to me in my addiction was the lose of my daughter to the disease of addiction. She had started using and she used crack before I did. And she told me, mommy, do not pick that up. But I always had a mind-set that anything that I used I controlled. It was a mind over matter thing. So I knew, did not think that I would have a problem because I had been using for a number of years. And working and doing all the things that I am used to doing. And I picked up crack, picked up a rock. And I never thought anything that small could bring me to my knees. Seven years of pain.

For 2 years after my daughter's death I was still on a downward spiral with the crack. I isolated, cut myself off from everybody. I worked, used and, you know, that was it. You know, I had two sons and two grandsons. But I thought I was being a mother too because, like I said, most of my addiction I worked. But basically, I was not being a mother to them because I could not even take care of me. My oldest grandson is blind, he has been blind since he was 3 years old. So he was 13 when his mother passed. And he saw the devastation of my daughter's disease and my disease. So I allowed him to move out of my house.

There is a lot of things that I could tell you that I could not write down, you know. You all said to me, we have 5 minutes. But I want you to feel what an addict feels, you know.

I did everything, stopped going to corners. I would go—I did not know that I was an addict because I was not out there on the corners, I was not using dope, I did not have the big hands and all of that, you know. So being a functional addict, you know, I worked. You know, I did not sell my body, I did not do the things that they did out there. So I was not an addict.

I continued until I fell on my knees. And I asked God for some help. That is how I was led to the Tuerk House. I did not know what Tuerk House was. When I stepped up those stairs at the Tuerk House. I did not know Tuerk House was a treatment center. I thought it was a halfway house dealing with people coming from

jails or somewhere that they needed a place to go. But I knew I needed some help. And I did not know what to do. So I went up those stairs and I went into the outpatient side and I asked for some help.

And they told me I was dealing with grief—or I was not dealing with my grief. I was not dealing with my depression. The higher I went up on cocaine the harder I crashed on cocaine. I knew nothing about the drug. A drug that I was sending through my body, I knew nothing about. I was actually killing myself.

And Tuerk House saved my life. Tuerk House brought me in on the day of my daughter's death. It was my lifegate. My daughter died like August 25, 1997. I came to August 25, 1999, exactly 2 years to the day of my daughter's death. So I considered my lifegate to her death day today.

I did a 28-day treatment program where I got information on the disease of addiction. Went through the continuing care program where I continued to get more information on my disease, because it is an ongoing process. I also got with people just like me to help each other, who help each other to get better a day at a time.

By getting through these two programs at Tuerk House I had gotten better with me. By going through the recovery process I was allotted the opportunity to give back in a special way. I now am a staff member at the place where I got my help. I coordinate a group called the peer support group. This group is a tool for relapse prevention. It is a self-help support group. The members of this group were clients in the Tuerk House program and joined this group on a voluntary basis, volunteer basis to help—get extended help.

Members of the peer support group are allowed to come as long as they want. The disease of addiction is for a lifetime. So we have to continue to do work on our recovery. That is what the peer support group allows its members to do.

We help each other by sharing our stories and commitments, such as the Baltimore City Detention Center, the Johns Hopkins/Bayview CAP Program which helps pregnant women, most of who are addicts, the Maryland Youth Center and the Mountain Manor Youth Center where a lot of our youths are in there have the problem due to the fact of parents and family members being on drugs. And that is the only lifestyle they know. Also we go in and we try to give them some help to guide them back to the right path.

At our weekly peer support meetings we use topics that help us deal with different things we go through on a daily basis such as relationships, let go and let God, change you must or die you will, anger problems, steps and traditions that are dealt with through the fellowship.

We let group members know that they must network together, go to meetings, share, and reach out to others to help in their recovery process. We share information with others that may not know that they have a problem, or know that there is help for them. All these are important tools to help each of us to recover, in our recovery and to help others in their way, to find their way to recovery.

And the final thing I would like to say is, I am doing this to let you know that we do recover. My daughter's birthday would be

Sunday. She would have been 32 years old. If she had some information, if I had had some information about the disease of addiction, that we had a disease and not just—did not know—wanted to get high. When we wanted to get high. We had a disease that was uncontrollable. And a lot of people have died because they do not have this information. That is why it is so important for the treatment and the educational part to get to these people that are still out here using.

I thank you for giving me the opportunity to speak to you.

[The prepared statement of Ms. Seward follows:]

Testimony of Elizabeth Seward,
Coordinator of the Peer Support Group, Tuerk House
House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy, and Human Resources
Baltimore, Maryland, March 5, 2002

Hello, my name is Elizabeth Seward. I am a recovering addict and a graduate of the 28-day program and the outpatient program at Tuerk House.

I will tell you my story briefly. I began using drugs to fit in and it started out as fun. I was a functional addict for 20 years. I worked as a factory worker and trained machine operators throughout my addiction, which kept me from understanding that I was an addict. Then at 39, I started sniffing cocaine, which led to my using crack, which devastated my life for 7 years.

In 1997, one of the worst things to happen to me in my addiction was the loss of my daughter to the disease of addiction. She started using crack before I did and told me "Mommy, don't pick that up." Because I considered myself a functional addict, I told her there was nothing that I put in my body that I could not control. For me, it was a mind over matter thing, not believing that something as small as a rock could bring me to my knees.

For 2 years after my daughter's death, I was still on a downward spiral with crack. I didn't understand that I was in a depressive state and that the more I smoked cocaine, the harder I crashed. I did everything except stand on corners. In the end, I was only working and coming home to use. This continued until I fell on my knees and asked God for help.

With that prayer I was led to Tuerk House. I walked in and let them know I had a problem. I had no idea about recovery. Tuerk House taught me that I didn't have a moral deficiency; I had a disease. The Tuerk House philosophy is that we feel the way we do because we think the way we think. And we need to change our thinking.

I did the 28-day inpatient treatment program where I got information on my disease and then went into the continuing care program where I continued to get information on my disease. I also got with people just like me who help each other to get better one day at a time. By getting through these two programs at Tuerk House I have gotten better with me. By going through the recovery process, I was allotted the opportunity to give back in a special way.

I'm now a staff member at the place where I got my help. I coordinate a group called the Peer Support Group. This group is a tool for relapse prevention. It is a self-help support group. The members of this group were clients in Tuerk House programs and joined this group on a volunteer basis to get extended help. Members of the Peer Support Group are allowed to come as long as they want. The disease of addiction is for a lifetime. So we have to continue to work on our recovery. That is what the Peer Support Group allows its members to do.

We help each other by sharing our stories at commitments such as the Baltimore City detention centers, the Johns Hopkins/Bayview CAP program which helps pregnant women most of who are addicts, the Maryland Youth Center, and Mountain Manor Youth Center.

At our weekly Peer Support Group meetings, we use topics that help us deal with different things we go through on a daily basis such as:

- relationships,
- let go and let God,
- change you must or die you will,
- anger, and
- steps and traditions.

We let group members know that they must network together, go to meetings, share, and reach out to others to help in their recovery process. We share information with others that may not know that they have a problem or know that there is help for them. All these are important tools to help each of us in our recovery and to help others to find their way to recovery.

Thank you for giving me the opportunity to speak with you today.

Mr. SOUDER. Thank you for being willing to speak out. And we appreciate the information from each of you. Congressman Cummings.

Mr. CUMMINGS. Thank you, Mr. Chairman. Mr. Johnson, Dr. Johnson, I am sorry, the Steps to Success report, it seems like something like this would have been before somewhere. Why do you think that has not happened?

Dr. JOHNSON. There is a long, there is a huge commitment from Mayor Schmoke in the very beginning to the city of Baltimore. And the city officials as well as Peter Beilenson were really invested in finding out how Baltimore was doing. And it took a very coordinated effort on their part to start it. And then they worked in collaboration with the universities.

So it took a long time to think about doing it, to get the political support to find the money to do it. And we have had these program evaluation techniques for a long time. We know how to do it. But we have the backing of the city to really explore the status of Baltimore's substance abuse treatment system.

Mr. CUMMINGS. Perhaps you and Dr. Beilenson may want to respond to this. When you do a—you all know research and how you validate research. I was just wondering, when you have a study in which a lot of the information is self-reported, I mean, does that effect the outcome? I mean——

Dr. JOHNSON. Well, we——

Dr. BEILENSON. A lot of it was not self——

Mr. CUMMINGS. OK.

Dr. JOHNSON. We actually have urine data to corroborate the self-report findings.

Mr. CUMMINGS. OK.

Dr. JOHNSON. And we have archival data which is from the criminal justice system to corroborate the self-report findings as well. So the criminal data that you see there is not self-report. It is from the criminal justice system of Baltimore, actual arrest records.

Mr. CUMMINGS. Dr. Beilenson, when you read the report was there anything that surprised you?

Dr. BEILENSON. No. You know, we have been talking about this, I have been in this job for 10 years. It is clear to me, as it is I know to you from hearing you in the many venues, that this is the most significant problem facing Baltimore. You know, it affects the economy of the city, it affects the educational system, it affects the housing system, and it clearly affects health and obviously crime. And we, I mean, it is lovely to have this study. But there is nothing surprising in it because we know treatment works.

Mr. CUMMINGS. Ms. Seward, thank you. I thank all of you for your testimony. But I was just wondering when you went from cocaine to crack, you in your testimony it sounds like that was a major move. I mean, as far as your life, devastating your life was concerned. Is that true?

Ms. SEWARD. Yes.

Mr. CUMMINGS. Why?

Ms. SEWARD. I lost a 17-year job within a year-and-a-half of picking up crack. I knew I had a problem that something was wrong, but I did not know what the problem was.

Mr. CUMMINGS. So you were, I think you used, you said you were a functional addict.

Ms. SEWARD. Yes.

Mr. CUMMINGS. So in other words, with cocaine you could function.

Ms. SEWARD. But I only used cocaine maybe about 6 months before I picked up crack.

Mr. CUMMINGS. And so when you picked up crack then——

Ms. SEWARD. The crack was, it was just an ongoing thing, you know, where I would go to work normally. Sometimes I would go to work after being up all night long smoking. And I would go in and I would be trying to do paperwork and going the things that I would normally did. I was going to put myself and other people's lives in danger, you know, because I could not focus. My focus was getting through that 8 hours or 10 hours or whatever I would have to do to get back home to go back to crack.

Mr. CUMMINGS. If you had had insurance then that covered drug problems would you had taken advantage of it? Or did you?

Ms. SEWARD. I am not sure. Well, let me put, they had just started I think with treatment, sending people to treatment on my job at that time. And because I did not know that I had a problem, I did not—it would have never even crossed my mind at that time.

As a matter of fact, I had a friend of mine that was in recovery for 3 years. I put him in danger because of about 6 months of my addiction I hid it from him. And understanding today that what you can do to a person that is in recovery if you were using, you know.

I know that today. But then I had no information. I knew nothing about recovery. You know, I did not understand it, the concept of recovery.

Mr. CUMMINGS. And how long were you on crack?

Ms. SEWARD. Seven years.

Mr. CUMMINGS. And so just a short period of that time you worked or——

Ms. SEWARD. I worked most of my addiction. I did a geographical change. As a matter of fact, after I lost the—my 17-year job and moved because I do not have family here. So I moved back to where my family was. My family put me back on the right track. Now understanding that I am an addict so I take it with me. So when I went to move back to Virginia, I just moved—I just found crack there then. I was getting high all over again.

Mr. CUMMINGS. Now you offer a very unique perspective and probably is a good person to answer this question. One of the things that we are always concerned about and we try to figure out is how do we provide effective treatment. Effective. Now you have been on the addict side and now you are on the treatment side. And you might want to also answer this, Mr. Hickey. What are the elements that you believe have to be in an effective drug treatment program?

Ms. SEWARD. Well, for me, the 28-day treatment is fine. But once you come out of there, the information in those 28 days with comparing that to being out there on the street for 20 years getting high, that is not enough. So we need to focus on is the outpatient part of treatment.

Because like I said, it is a lifetime disease, just like any other disease. I had to have continuous care. Or if you do not, you are going to end up relapsing or go right back.

So one, continued care at the Tuerk House, we had 36 sessions that they go through. But my group which is the peer support group is an ongoing group of self-report, self-help supporters. We support each other. And we have been pushing for to make this in other facilities because we all came out of the Tuerk House, did the 28-day, did the continuing care. But we know we need more. We need to keep in contact with each other as well as the facility we came out of if you are continuing care going.

Mr. CUMMINGS. What happens when somebody that you have been real close to in the group and who has been a real, I mean, doing a good job and of course, like you said, you are supporting each other, and somebody then relapses? I mean, how does that affect you?

Ms. SEWARD. That is kind of hard. But I understand that some people have to have a relapse in their story. So we are still there for them. We do not go and pull you out of the crack house and pull you out of the—but when you decide to come back we are there for you. We just continuously give each other support.

Dr. BEILENSON. By staying connected what we see is that you can minimize what the slip, you can keep it from becoming a total relapse. When we graduate people and discharge people and we give them the idea, now kind of we have taught you everything you need to know to survive out there, what happens when they have a slip is they are very embarrassed to come back. They are ashamed and say, I am in trouble. So you will see them try to manage the slip on their own. And they will—when they finally come back it is 6 months later and they are a mess, you know.

So what we really try to do is, and trying to do on a larger level, is keep people connected and to feel comfortable and saying, I am in trouble. Can you help me, you know. The definition is it is a chronic relapsing condition. Certainly for the folks we see that have ten, 20, as Judge Weitzman said, 10, 20, 30 years. They are in late-stage addiction.

If you come into Tuerk House, you are in late-stage addiction. You are not experimenting with drugs. You are drug dependent. And you may well experience a relapse. So we have to make sure they know if they are in trouble, even before they pick up, that is the key. Before you pick up and you are thinking, hey, are you in trouble, you need to know you have friends that you can come back and talk to that have been through it. And you need to know you can walk up to a counselor and there is no judgment about, oh, you failed or you are a bad person or any of that. And that is kind of what this peer support effort is about.

But we see it with case management. If you leave Tuerk House we send you to an outpatient program somewhere in the city. But we, from a small case management project we did in the last year, you could see that when people would be falling out of that outpatient treatment, a good chance the case manager would have been actually tracking them to make contact to get them back in. So what you ultimately do by investing on a kind of a long-term

community-based support system is you maximize what you have invested in this residential treatment, which is expensive.

Mr. CUMMINGS. Thank you.

Mr. SOUDER. Dr. Beilenson, I had a few requests on your chart. That one, the effective increased treatment on drug use and crime. Could you provide us with a list of, for the record, of where you got the—which hospitals you used on the ER's and what—and which crimes were combined together to get violent crimes? Do you have a chart that takes us back 10 years?

Dr. BEILENSON. I am sure we could. We have not done that but I am sure——

Mr. SOUDER. OK. If you do not have it we could try to assemble that, too, if just make sure we compare it apples to apples. Also, do you know whether the numbers of arrest went up during these years or prior to it, which also would take people off the street?

Dr. BEILENSON. The arrests went up slightly the last year or two. But and that may or may not have played into it. One, on your request, if we could do it 7 years. Because the blue data, that emergency room data, comes from DAWN, which I think is only 7 years old. So——

Mr. SOUDER. Try to get apples to apples we will do that.

Dr. BEILENSON. So that would make it 1994.

Mr. SOUDER. Yeah, something like that. And did you pick 1999 because that was the year——

Dr. BEILENSON. The year the mayor started.

Mr. SOUDER. OK. I understand that. Do you know whether the, because we will also look at this data, whether other around counties had the ER and violent crime rates go down?

Dr. BEILENSON. They would not know that because the DAWN study which that is based on the national study, was the top 21 cities in the country. So no other city in Maryland would fall in that. It would be comparing, you know, Indianapolis, Washington, DC, Chicago, those kinds of cities.

Mr. SOUDER. But there is a—and you have compared to those other cities?

Dr. BEILENSON. Correct. That is what the mayor and Lieutenant Governor, the single biggest drop in this, in DAWN data, in this emergency room data, was in Baltimore of the 21 big cities.

Mr. SOUDER. What about in the violent crime?

Dr. BEILENSON. We have the largest drop, 2 year drop in the last couple of years in America.

Mr. SOUDER. Now the violent crime data, one of the reasons to get the crime—the fundamental problem we have in Congress and each of us as a member is the crime rate, generally speaking, has been coming down everywhere.

Dr. BEILENSON. Right.

Mr. SOUDER. And that different people attribute different programs for that. For example, one area may have boosted their education. One area may have boosted their job training. One area may have new—they have reduced dramatically the number of kids who are assigned to probation officers. And then they say that is the reason that the crime dropped. There is no arguing that individually the treatment programs help the individual.

What is the harder argument is to make the collective argument. And we have to make sure that the data is in fact the classic studies on this. And in fact, Baltimore was in this, and Minneapolis on teen pregnancy, that where certain programs are put into the schools the teen pregnancy rate dropped in Minneapolis. But nationally dropped greater in the areas around it where they did not put the programs in.

And so we have to make sure that we—that this is not a question of a——

Dr. BEILENSON. A trends data.

Mr. SOUDER. Yeah. It is not—well, it is not just trends. It is that when we see a change in society's behavior patterns, we have to make sure which variables were causing the change on a collective basis as opposed to an individual basis. Because the truth is is that, as you have pointed out, not that many people are able to get into the intensive treatment programs in proportion to the number of people who are——

Dr. BEILENSON. We are getting about 22,000 folks out of our 50,000 to 55,000 addicted individuals in treatment each year. So it is a sizable percentage of them.

Mr. SOUDER. And that presumably would cause a reduction when you are reaching that many. But that is why I wanted to see whether there were other trends that were helping more of those people be willing to come in, whether there are other trends. And one way you measure that is compared to other cities like you attempted to do. And then also to the communities in the immediate adjacencies which may or may not have the ER rates but they would have the violent crime rates. And we have the mix of what crimes they were.

Miss Seward, first I want to than you for your willingness to speak out. And certainly express our praise for you in changing your life and sorry that we were not able to reach your daughter. That individuals ultimately have to bear responsibility, but society should do everything they can to help individuals to try to overcome those problems and provide that assistance.

You mentioned that, have you talked with other people, obviously you are as a peer counselor, who have dealt with cocaine and heroin addictions. You said that you started with marijuana and alcohol. Do you know anybody who did not start with marijuana?

Ms. SEWARD. Most addicts have started with alcohol or marijuana. Marijuana is considered the gateway drug. We start out smoking it for fun, you know. And ends up leading us to the next one and the next one and the next one.

Mr. SOUDER. Did you use any kind of cocaine besides crack?

Ms. SEWARD. I sniffed cocaine for about 6 months.

Mr. SOUDER. And the crack made it more difficult for you to function at work than the cocaine did?

Ms. SEWARD. Yes. Yes, because the crack, the chemicals in the crack, that is why I sniffed so bad. Not because of the chemicals—I mean, that is all it is now, is chemicals. But back then it was less chemical. And I functioned but I did not function to what I normally was able to function. Because I stayed up. Crack keeps you up all night, you know.

You stay going out and buying, going out and buying. And by the time you look up the sun is coming up, it is time for you to go to work, you know. And you may really like crash unless you got another bag. If you got another bag you might choose not to go to work, you know. That is how devastating that is. Or it was for me.

Mr. SOUDER. One of the most difficult problems that we are trying to sort through in Congress is how to deal with this difference in penalties between crack and powder. Because it is disproportionately impacted in the African-American community on crack. Now Congressman Rangel originally introduced the stiffer penalties for crack because of that impact particularly on youth. Now I do not know whether we will wind up probably splitting the difference, raising one. But it has become an inequity. But it is helpful to understand how the inequity originally occurred. Because it does have a disproportionate impact.

You also mentioned in your testimony that you asked God for help. Do you say in your peer support group that you go through let go and let God work in your life. Also, Judge Weitzman said that spirituality was undergirding many of the people who recover. What percentage of the people who you work with would you say that is a key component if they have had a recovery?

Ms. SEWARD. The majority of have asked God—have found spiritual connections again. Because once you put a drug for me, we always keep it in our statements for me, once you put a drug in your system you are dead in the spirit. That is why you do not have no conscious. The more you use the less conscious you have, right.

You are removing yourself from God's world and going to your world. And that is why you have to get your spiritual connection back. Once I fell on my knees and said, God, please help me. He guided me where I had let my world go, you know. Because I had beat myself up so badly that I thought that God was there. But God was there for me all the time. I just left him. So I found my way back to him. And he has helped me in this process from 2½; 2-years and 7-months I have been in this process.

So and that is the way most of the group members feel. If it was not for God's intervention through the courts, through the police, the cops picking them up off the street, through the judges, through a counselor at Tuerk House or another treatment facility. We look at them as our guardian angel. They led us back, you know. They gave us the information to help us save our lives, you know, working through people.

Mr. SOUDER. Thank you for offering your testimony. Mr. Cummings.

Mr. CUMMINGS. Just to close out again, I want to thank all of you for being here. Ms. Seward, I want to go back to something that the chairman said. I too congratulate you for what you have been able to accomplish. And I too wish that we had been in a position to save your daughter.

And I was just thinking about how depending on when we are born and where we are born and the environment we are in really kind of dictates in any instances what our lives will be like. And so a lot of people may ask, what is, you know, what are these hearings all about. It is an effort, first of all, to gather information so

that we can then take that information and mold policy that can help people. That is what it boils down to.

And so our, is sort of trying to figure out what works. And it is good to have the testimony of people who deal with this up front and personal so that we can then, hopefully, come up with the solutions that will save people like your daughter, and provide the opportunities like you are, you have been provided at Tuerk House, and so that we can be effective with what you the tax payers are paying every dime of, you know, various programs.

And so we want to just make sure that we spend that money effectively and efficiently. And the more effectively and efficiently that money is spent, the more likely it is that we will be able to get more funds to do the same kinds of things. And so, you know, as being a legislator for now 20 years, I realize that you do things 1 day at a time, just like the—you know, you have a hearing there, you bring the Drug Czar in there, you do something here. And, hopefully, you gather enough information and bring enough people together who are thinking somewhat the same. You have the research done and whatever.

The people begin to say, wait a minute. This is what we need to be doing just like Judge Weitzman. I think if somebody saw, somebody like her come up and say, you know, this is the most effective thing I do. And so you get a combination of people, black and white, all colors, races and old, young, whatever, and bring them together. Then society, finally a lightbulb goes off and says, you know, we need to do this. We need to address this. And I think saw, Peter, from testimony like yours. We are slowly seeing the society say, this is all of our problem and not just throwing people away and saying, they made a mistake and we will see you later. Let us move on.

But, you know, the President and others talk about leave no child behind. I think what we are trying to do is get to the point where we say we leave no person behind. So I thank everybody for everything you have done. And thank you, Mr. Chairman, for holding this hearing in Baltimore today.

Mr. SOUDER. Thank you very much. We appreciate getting your input into the global picture as we try to tackle it. But ultimately, you are down on the street too winning each soul one by one. I remember years ago and when I was with the Children Family Committee I spent a number of different times up in Newark. And I met this man who worked with Intervarsity Fellowship. He said when he first started in the volunteer work, which is basically 24 hours a day, had not taken a vacation in I think something like 10 or 20 years, had got involved in his community. And often it is the people who are there. The problems do not usually occur 9 to 5. And he was around the clock. And he said, I came here. And when I first decided the street ministry and work with the kids and he said, I thought I could save all of Newark. And then it was South Newark. Then it was my neighborhood. Then it was my block. Now if I can just reach one kid at a time.

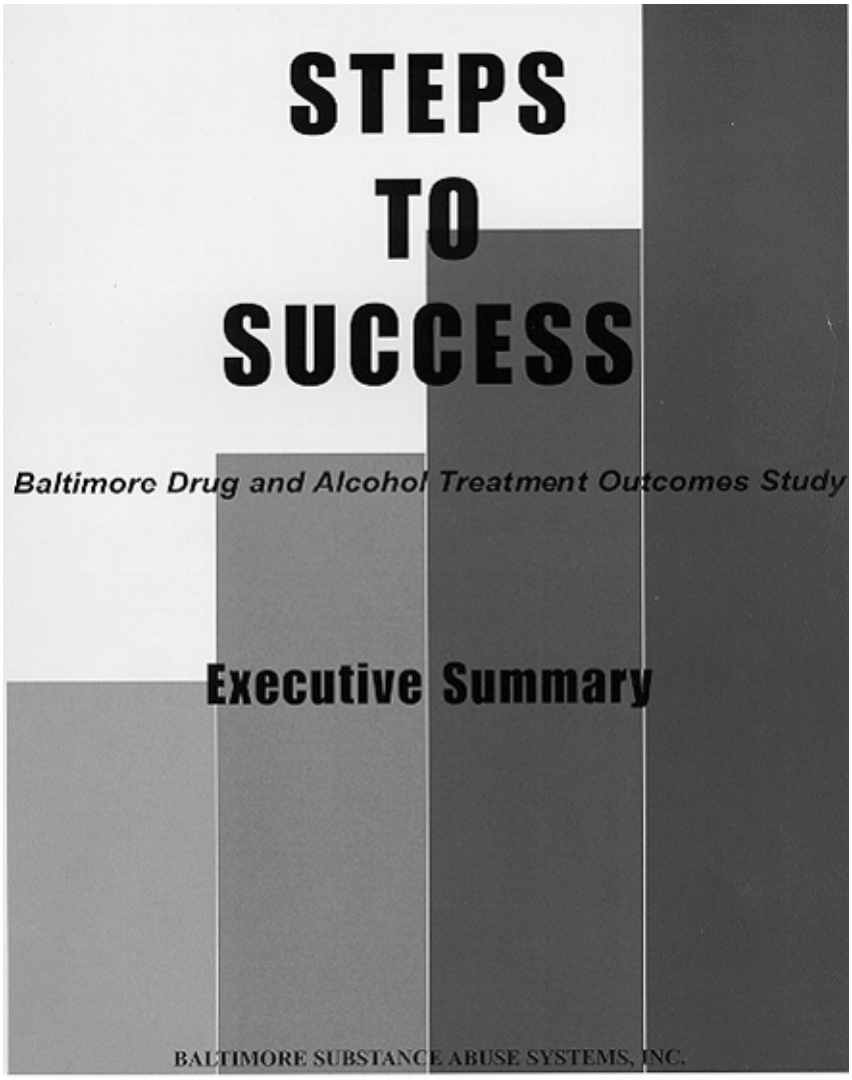
And we appreciate your work doing in that and inputting us as we try to tackle the global. But ultimately, it is the people down in the street talking to the individuals who are doing the yeoman's work. And we appreciate that.

With that, our subcommittee stands adjourned.

[NOTE.—The report entitled, "Office of the District Attorney Drug Treatment Alternative-to-Prison Eleventh Annual Report, 2001," may be found in subcommittee files.]

[Whereupon, at 12:23 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]


STEPS
TO
SUCCESS
Baltimore Drug and Alcohol Treatment Outcomes Study
Executive Summary
BALTIMORE SUBSTANCE ABUSE SYSTEMS, INC.

January 24, 2002

The report you are about to read, commissioned by Baltimore Substance Abuse Systems, Inc. (BSAS), shows conclusively that drug treatment is effective in Baltimore City. It is tempting, when presented with research of this caliber, to trumpet its findings with great fanfare; but addiction is nothing to celebrate. Many addicted Baltimore residents lead lives of quiet desperation, shielded from public view except when drug-related crime makes the front page of the morning paper.

For years, Baltimore has cited national studies on the effectiveness of drug treatment. Three years ago, we began our DrugStat program to closely monitor treatment program outcomes in order to strengthen performance. Now we have the first system-wide analysis demonstrating that, in Baltimore City, treatment works. In 1999, Baltimore City and the Maryland General Assembly began a partnership to substantially increase investment in drug treatment. This commitment, if fulfilled, would increase by $25 million funding for Baltimore City's treatment system. Any wise investor would seek evidence that his/her dollars are well spent. This new data is proof of the logic and public health benefit of making treatment available "on demand."

This study shows that, as we continue to invest in drug treatment, we can expect dramatic reductions in crime, overdose deaths and drug-related emergency room visits. We are more confident than ever of the effectiveness of drug treatment and are armed with findings that prove what treatment practice and common sense have told us. As a result, we must redouble our efforts to provide drug treatment for all who need it.

We are indebted to the University of Maryland, Johns Hopkins University, and Morgan State University for their collaboration and commitment to excellence. Finally, I would like to offer a special thank you to the treatment providers of Baltimore City who labor long hours to meet incredible demand.

And yet, we cannot pause long to celebrate nor indulge much in congratulation, for with this data comes a public health responsibility to make "treatment on demand" a reality. I am heartened to open this new year, a fresh legislative session before us, with the much-anticipated release of the Baltimore Drug and Alcohol Treatment Outcomes Study. May it strengthen our convictions that our work makes a difference.

Peter L. Beilenson, M.D., M.P.H.
Baltimore City Health Commissioner
Chairman of BSAS Board of Directors

Introduction

The *Baltimore Drug and Alcohol Treatment Outcomes Study* is the largest and most rigorously conducted drug treatment outcomes study that focuses on a single city. It is one of the key components of Baltimore's strategy to rigorously evaluate and continuously improve the public treatment system, as it expands to meet the needs of the city's uninsured citizens. Overall, the study found a marked reduction in drug and alcohol use, crime, risky health behaviors and depression among participants who voluntarily entered publicly funded outpatient drug and alcohol programs in Baltimore City. This comprehensive study is the result of an unprecedented collaboration among the University of Maryland, Johns Hopkins University and Morgan State University, with the cooperation of 16 treatment programs and nearly 1,000 treatment participants. Baltimore Substance Abuse Systems, the agency responsible for publicly funded treatment in the city, funded the study.

Methodology

The data included in these analyses represent findings from 991 uninsured Baltimore City residents who voluntarily entered outpatient drug and alcohol treatment through 16 publicly funded programs from 1998-1999. Two kinds of programs are included in the study, those that treat heroin addicted individuals with methadone and counseling and those that treat alcohol, heroin, cocaine and other drug users with counseling only. All study participants provided informed consent and completed an initial assessment; the 991 reported in detail here also returned for at least one treatment session. Since this subset of 991 participants may have received as few as one treatment session, treatment outcomes represent conservative estimates of the benefits of treatment. In keeping with the methodology of earlier national studies, participants' self-reported behaviors at treatment entry were compared with those reported at one, six, and 12 months thereafter. While self-reports under confidential research conditions have been shown to be generally valid, investigators also examined objective measures of drug use and crime, including urine drug tests and official arrest and imprisonment records.

Participants

The average participant in the *Baltimore Drug and Alcohol Treatment Outcomes Study* was 37 years old. Nearly 50 percent were women and 85 percent were African-American. Three-quarters of the clients treated were unemployed and had an average annual income well below the poverty line, indicating that the public treatment system is fulfilling its mission to serve individuals who otherwise could not afford to enter drug treatment. On average, participants reported using heroin on 18 of the 30 days prior to entering treatment entry, using cocaine on six of 30 days and drinking to intoxication on four of 30 days. Given the difficulty women often face in entering treatment, the large proportion of women who participated in the study indicates that stigma surrounding substance abuse is not an insurmountable barrier to seeking treatment.

Reduction in Drug Use

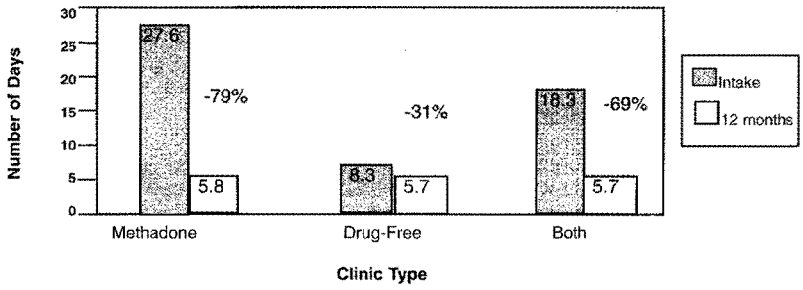
Overall drug use among participants was significantly reduced as early as 30 days after treatment and remained below the pre-treatment levels at 12 months. These reductions in drug use are consistent with those found in large multi-city trials that have been conducted over the past 20 years. Urine drug testing confirmed over 70 percent of the self-reports of cocaine abstinence and over 75 percent of the self-reports of heroin abstinence. These high rates of agreement between self-reported drug use and urine results are also consistent with earlier studies and support the accuracy of self-report data.

Heroin Use

Heroin use declined at statistically significant rates for all treatment participants. Over the first 30 days of treatment, heroin use declined by 72 percent. This improvement was sustained at 12 months after intake (69 percent). Clients enrolled in methadone programs used heroin three times more frequently in the month prior to intake than clients enrolled in drug-free treatment. The decline in heroin use was greater for those enrolled in methadone programs at the one, six and 12 month follow-up interviews than for those enrolled in drug-free treatment.

Despite the widely recognized difficulty associated with discontinuing heroin use, drug treatment was associated with a remarkable and sustained reduction in heroin use up to one year from treatment entry. Heroin use contributes significantly to overdose death, emergency room visits and associated infections such as hepatitis B and C and HIV. The proven effectiveness of heroin treatment underscores the need for treatment capacity in those programs.

Treatment Reduces Heroin Use

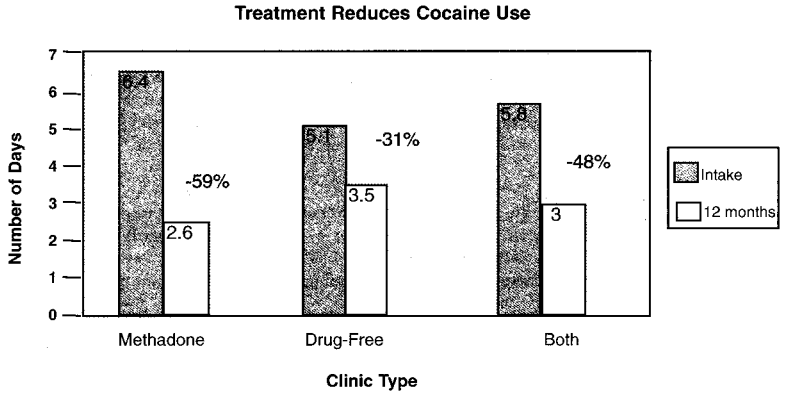


This figure shows the average number of days clients used heroin within the 30 days prior to intake assessment and the 12 months after initiating treatment services.

Cocaine Use

There was a statistically significant decrease in participants' cocaine use over the 12 months following treatment entry. Cocaine use declined by 64 percent at 30 days from intake, 43 percent at six months and 48 percent at 12 months. Clients enrolled in methadone treatment had a higher baseline level of cocaine use (6.4 days) than those enrolled in drug free treatment (5.1 days). There was a greater decrease in cocaine use among participants in drug-free programs compared to participants in methadone programs over the first 30 days of treatment (70 percent vs. 59 percent). Although both groups maintain improvement at six and 12 months, cocaine use declined at a lower rate among participants in drug-free treatments than among those in methadone clinics.

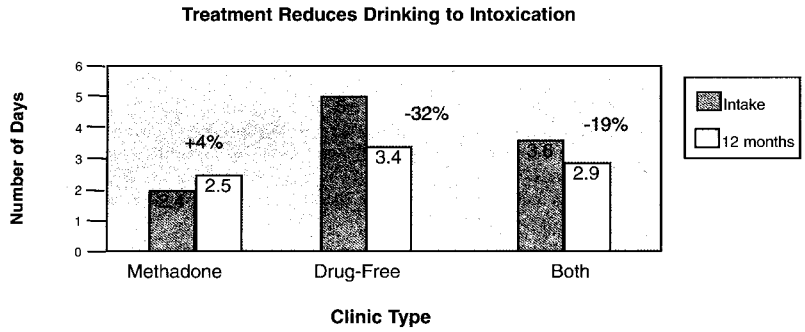
The erosion in improvement for drug-free clients is probably due to the higher dropout rate seen in these clinics compared to methadone programs. Treatment retention has repeatedly been linked to improved outcomes. Efforts by Baltimore to improve treatment retention, such as its Drug Stat Program in which outcomes are reviewed monthly by the treatment program directors, BSAS staff and the Health Commissioner to hold programs accountable and improve performance, are therefore critical to increased success.



This figure shows the average number of days clients used cocaine within the 30 days prior to intake assessment and the 12 months after initiating treatment services.

Reduction in Alcohol Use

The study finds a statistically significant reduction in overall alcohol use during the 12 months following treatment entry. The average number of days of drinking to intoxication declined by 64 percent at one month after intake and 34 percent at six months. By 12 months after intake, participants reported drinking to intoxication 19 percent less than they had at intake. These findings indicate that treatment significantly reduces heavy drinking over the first month of treatment and, though the improvement attenuates over time, heavy drinking remains considerably less frequent (19 percent) even after one full year after the start of treatment. Participants treated in drug-free programs had greater alcohol problems at baseline and showed greater and more sustained improvement than those participants enrolled in methadone treatment.



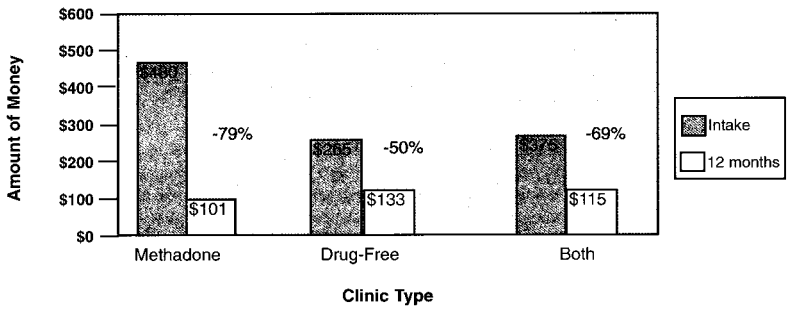
This figure shows the average number of days clients drank to intoxication within the 30 days prior to intake assessment and the 12 months after initiating treatment services.

Reduction in Crime

Researchers and law enforcement experts have linked the illegal nature of behaviors associated with drug addiction to crime. The legal problems of study participants improved significantly over the 12-month study follow up period, confirming previous national studies that indicate that addiction-related crime decreases significantly as a result of effective treatment.

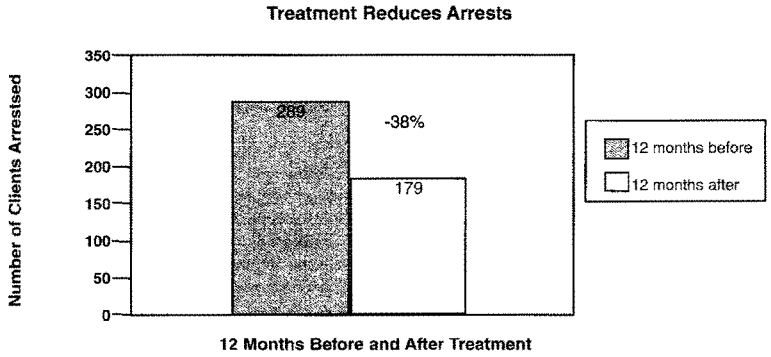
Participants engaged in illegal activities 64 percent less at 12 months after treatment entry. Participants also significantly reduced the amount of illegal income they received by 77 percent at one month after treatment entry. At 12 months after treatment entry, the amount of illegal income remained low at 69 percent below levels at the start of treatment. This decrease occurred among participants in both kinds of treatment, although the methadone participants started at a higher level of illicit income and improved more markedly than the drug-free clients. The other self-reported drops in crime days, illegal income and drug use all underscore the importance of drug treatment as a key part of Baltimore's crime reduction strategy.

Treatment Reduces the Receipt of Illegal Income



This figure shows the amount of illegal income received by the clients in the 30 days prior to intake and the 12 months after initiating treatment services.

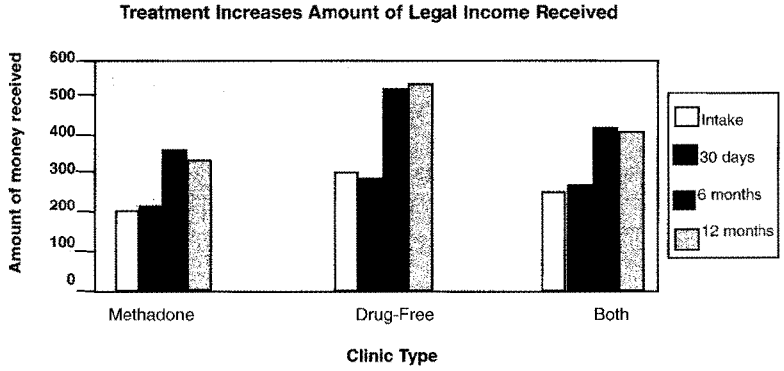
Official arrest records show a 38 percent decline in the number of treatment participants whose arrest led to an imprisonment in the 12 months prior to treatment (289 participants) compared to the 12 months after treatment entry (179 participants). These data must be considered preliminary, as there is often a time lag for sentencing, which results in an underreporting of the number of imprisonments during the follow-up period. Future reports, using additional data will update these preliminary findings.



The preliminary data in this figure are restricted to a subgroup of clients who were found guilty of crimes that led to imprisonment by the Division of Corrections.

Increased Earned Income

Treatment participants worked 52 percent more and earned 67 percent higher wages in the 30 days prior to the 12-month follow-up interview than they did in the 30 days prior to entering treatment. These improvements included "off the books" employment, which constitute an important source of income for marginalized populations. This informal labor market does not include illegal income but is characterized by a lack of health and other benefits, poor job stability and low pay. Though participants' income increased to an average of $415 per month, it remained considerably below the poverty level.



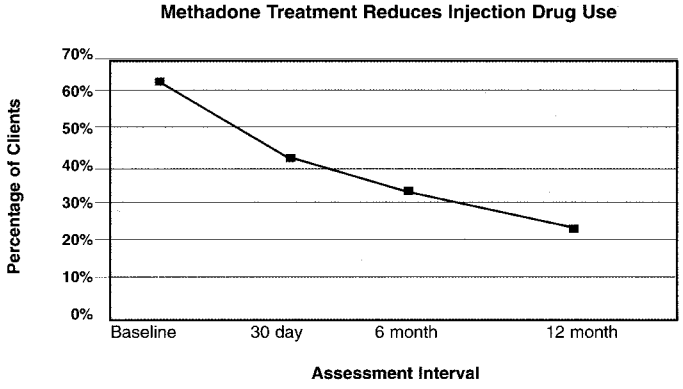
This figure shows the increase in the average amount of money earned within the past 30 days at each assessment period, separated by the type of clinic the client attended; then, both clinics are combined for an average of the clinics.

Decreased Depression

A substantial minority of people enrolling in drug and alcohol treatment had symptoms of depression at treatment entry. Study findings show a statistically significant decrease in depression scores across the study's follow-up intervals. Participants enrolled in methadone programs had more severe depression and more marked improvement than people treated in drug-free clinics. While many symptoms of depression improve with abstinence from drugs or alcohol, it is important to have anti-depressant medications and psychotherapy available for those clients whose depression does not spontaneously remit after drug and alcohol treatment alone.

Reduction in HIV Risk Behavior

Alcohol and drug dependence increases the risk of transmitting HIV, Hepatitis B and C and other sexually transmitted diseases through sharing injection equipment and unsafe sex. Study findings show a 59 percent reduction in drug injection among methadone clients at 12 months from the start of treatment. These robust reductions in drug injection reduce the risk of disease transmission.



This figure shows data from methadone clinics and is based on the response to the question, "Have you injected drugs in the past 30 days?" All time points cover the 30 days immediately preceding the evaluation.

Shooting galleries are buildings in which intravenous drug users congregate. They are a site of the spread of HIV, hepatitis and other sexually transmitted diseases through sharing of needles and other drug paraphernalia, as well as through trading sex for drugs. There was a statistically significant decline in the number of participants frequenting shooting galleries over the 12 months after entering treatment.

Benefits of Treatment- on-Demand

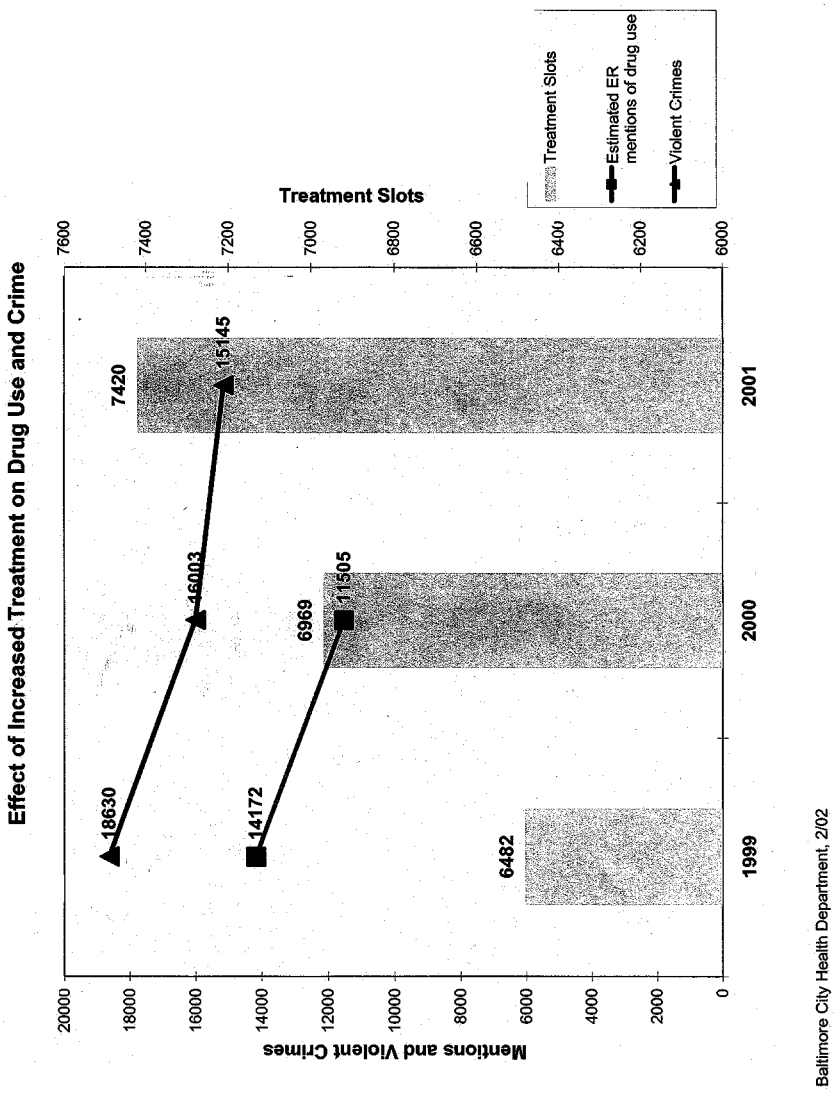
The benefits of treatment-on-demand for alcohol and drug dependent people can be measured by comparing participants' behaviors during the 30 days before they entered treatment with those reported in the first 30 days after entering treatment. Based on the average drop in drug use and crime in the first 30 days of treatment compared to the 30 days prior to treatment entry, treatment of an additional 1,000 people per year avoids: 164,000 days of heroin use, 45,600 days of cocaine use, 63,600 days of crime and $3.2 million in illegal income.

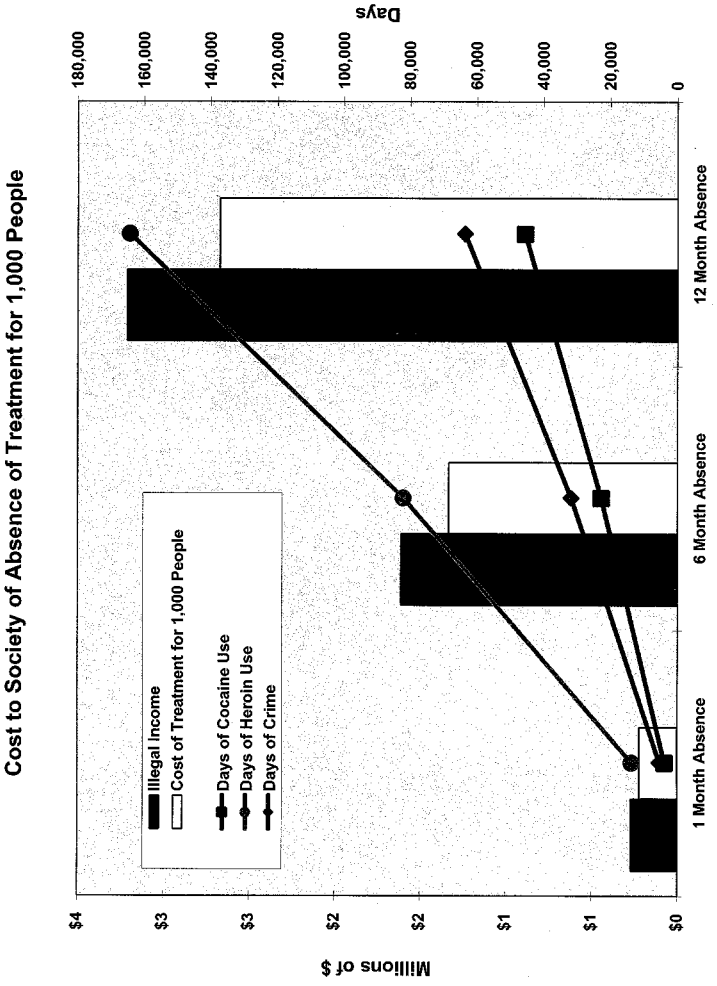
Negative Impacts on People and Society Resulting from the Absence of Treatment Services (for 1,000 people)

Behavioral Domain	30-Day Absence	6-Month Absence	12-Month Absence
Additional Drug Use			
Days of Heroin Use	13,700	82,200	164,400
Days of Cocaine Use	3,800	22,800	45,600
Additional Crime			
Days of Crime	5,300	31,800	63,600
Illegal Income	$267,850	$1,607,100	$3,214,200

Conclusions

The finding of *Baltimore Drug and Alcohol Treatment Outcome Study* are compelling as they confirm and build upon the results of other nationwide studies and upon documented trends in the past year in Baltimore (e.g., decrease in drug-related emergency room visits, overdose deaths and crime). Even after one year from treatment entry, participants significantly reduced their heroin, cocaine and alcohol use, decreased the number of crimes they committed, improved their psychological functioning, increased their legal income and reduced their risk of getting and transmitting life threatening diseases such as HIV and hepatitis. These findings support the efforts of the City of Baltimore and the State of Maryland to expand and improve the city's treatment system. Expanding the capacity of the public system will enable all city residents to have rapid access to high quality treatment services resulting in improved health and well-being for them, and their families and communities.

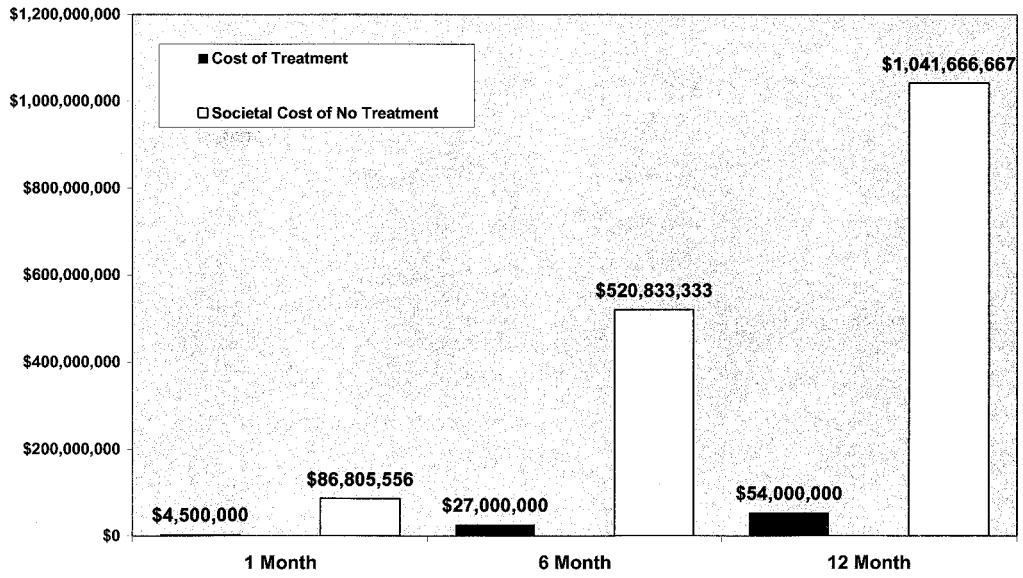

Effect of Increased Treatment on Drug Use and Crime
Treatment Slots
Mentions and Violent Crimes
Treatment Slots
Estimated ER mentions of drug use
Violent Crimes
7600
7400
7200
7000
6800
6600
6400
6200
6000
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
18630
16003
15145
14172
11505
6482
6969
7420
1999
2000
2001
Baltimore City Health Department, 2/02



Baltimore City Health Department, 2/02

From "Steps to Success"

Cost Savings of Treating 25,000 People



Baltimore City Health Department, 2/02

Societal Cost estimate based on Drug Strategies "Smart Steps" report

Methadone Maintenance

Program Name	Period	Retention at Month: 1	3	6	12	Rth Grant Static Capacity	Avg # of Clients Active	Utilization Rate	Urinalysis # of UA Tests	% Pos for Opiates	% Pos for Cocaine	% Arrested During Tx.	% Unemployed Who Become Emp. At Dis.	Average Length of Stay	Addiction Severity Index: Medical	Empl.	Drug	Alcohol	Legal	Family	Psych
	FY2000	96%	93%	80%		325	274	84.3%	1,536					707	.238	.751	.238	.086	.207	.182	.156
	FY01 Q1	98%	86%	83%	73%	325	303	93.2%	886	27%	24%			761	.242	.747	.348	.068	.214	.180	.154
	FY01Q2	95%	82%	73%	61%	325	308	94.8%	1,014	32%	25%			626	.235	.767	.333	.042	.261	.178	.127
ADAPT Gates	FY01Q3	96%	82%	73%	62%	346	334	96.5%	958	30%	25%			698	.214	.768	.339	.038	.266	.186	.116
	FY2000	84%	67%	44%		256	277	108.2%	2,108					227	.216	.751	.258	.134	.075	.150	.183
	FY01 Q1	88%	74%	56%	46%	256	267	104.3%	1,026	16%	7%			308	.277	.807	.314	.183	.208	.228	.194
	FY01Q2	95%	84%	76%	63%	256	237	116.1%	1,163	11%	13%			283	.190	.835	.217	.121	.085	.165	.133
ATS - Bayview	FY01Q3	82%	80%	45%	31%	256	263	153.5%						281	.182	.846	.207	.153	.175	.222
	FY2000	95%	78%	62%		335	253	75.5%	783					317	.384	.807	.398	.173	.225	.193	.194
	FY01 Q1	95%	81%	69%	57%	325	307	94.5%	929	32%	22%			311	.348	.802	.398	.162	.228	.167	.182
	FY01Q2	98%	77%	60%	50%	325	306	94.2%	1,002	33%	26%			181	.677	.869	.599	.504	.089	.478	.466
Daybreak	FY01Q3	96%	82%	71%	60%	325	256	78.8%	1,253	30%	31%			318	.319	.792	.396	.201	.413	.364	.456
	FY2000	98%	82%	65%		260	287	110.4%	2,007					606	.263	.766	.316	.056	.166	.162	.129
	FY01 Q1	97%	88%	73%	64%	325	325	89.0%	1,398	40%	34%			648	.243	.254	.779	.314	.038	.189	.180
	FY01Q2	99%	92%	84%	45%	365	324	88.9%	1,822	32%	30%			580	.228	.786	.977	.052	.101	.155	.107
Glenwood Life	FY01Q3	85%	77%	63%	46%	365	379	103.9%	1,708	31%	31%			643	.210	.773	.325	.047	.179	.151	.116
	FY2000	97%	90%	84%		300	408	136.0%	1,070					706	.245	.775	.332	.058	.176	.162	.261
	FY01 Q1	99%	91%	87%	84%	300	407	135.7%	1,513	29%	26%			671	.246	.766	.332	.056	.178	.168	.254
	FY01Q2	97%	89%	85%	82%	365	400	133.3%	1,629	19%	28%			626	.262	.846	.309	.057	.194	.176	.268
Man Alive Research	FY01Q3	99%	90%	84%	81%	300	365	98.0%	1,844	19%	26%			607	.213	.874	.268	.055	.196	.173	.258
	FY2000	99%	91%	77%		225	242	107.6%	2,746					592	.327	.782	.298	.086	.132	.158	.145
	FY01 Q1	98%	91%	78%	63%	285	283	99.0%	923	47%	28%			540	.312	.778	.268	.067	.133	.168	.144
	FY01Q2	97%	86%	75%	55%	285	294	102.8%	945	35%	30%			575	.363	.797	.309	.057	.194	.175	.268
New Hope Treatment	FY01Q3	85%	86%	75%	61%	308	308	107.7%	941	30%	37%			456	.351	.793	.331	.071	.208	.194	.143
	FY2000	98%	84%	49%		351	285	78.4%	3,691					525	.131	.744	.294	.044	.131	.107	.064
	FY01 Q1	97%	85%	53%	37%	366	342	88.8%	1,146	36%	21%			566	.146	.756	.293	.043	.134	.114	.071
	FY01Q2	99%	84%	48%	21%	366	315	81.8%	1,305	34%	22%			691	.078	.741	.264	.051	.126	.099	.035
Reflective Treatment	FY01Q3	97%	82%	44%	23%	366	279	72.3%	1,308	32%	21%			383	.099	.719	.291	.048	.118	.073	.040
	FY2000	92%	76%	65%		155	367	103.4%	2,071					376	.294	.783	.341	.054	.139	.119	.122
	FY01 Q1	90%	74%	60%	56%	301	382	130.2%	781	36%	25%			360	.283	.787	.341	.053	.128	.118	.130
	FY01Q2	92%	75%	69%	53%	301	303	100.7%	1,167	26%	28%			407	.204	.773	.342	.095	.203	.136	.158
Sinai Hospital	FY01Q3	85%	74%	57%	46%	301	302	93.7%	1,066	29%	28%			422	.223	.801	.319	.064	.162	.149	.127
	FY2000	84%	54%	41%		235	237	99.8%	2,432					548	.127	.352	.128	.028	.070	.053	.052
	FY01 Q1	83%	56%	43%	32%	309	278	90.0%	1,388	20%	24%			531	.337	.121	.121	.031	.086	.052	.062
	FY01Q2	83%	53%	40%	28%	309	280	90.6%	1,623	22%	26%			676	.216	.481	.183	.005	.127	.070	.079
University of MD	FY01Q3	82%	80%	45%	34%	309	314	101.6%	1,579	21%	23%			604	.281	.616	.293	.011	.159	.117	.118
Averages		94%	82%	66%	53%		307	101%	1,676	29%	29%			553	0.257	0.719	0.325	0.102	0.191	0.153	0.139
Benchmarks		95%	85%	70%	60%			100%		25%	50%	70%	25%								

Note: Q3 ASI and LOS data are based upon admissions/discharges during the period 4/1/1999 through 3/31/2000. Retention numbers are based upon admissions from 4/1/1998 through 3/31/2000.
* Clients at ATS have been discharged and readmitted when tapering status changes. This creates artificially low LOS and retention rates. The practice has been discontinued.

○