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Against the Odds: Therapeutic Community Approaches to Underclass Drug Abuse

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As the tide of casual drug use that crested in 1985 recedes, the United States must face what it has long ignored: the intractable and entangled wreckage of inner-city social ills. Addiction-driven criminality among the urban "underclass" is the force behind the dramatic growth of prisons, jails, probation, and parole. Always marginal, this population is increasingly separate from the middle-class experience and deviant from middle-class values. It will not and cannot respond to programs designed for mainstream society.

Effective interventions for urban underclass drug users must focus on methodology that is "habilitative" rather than rehabilitative, providing the very basics of healthy living. Emphasis must shift from individual recovery to community and institutional recovery. These community models must be long-term, comprehensive programs; they must include health care, basic education, job training, parenting skills, moral development, and community-building skills. Ironically, the cost of such intervention is minimal when compared with the escalating costs that result from ignoring these problems.

During the turn-of-the-century flirtation with cocaine in the United States, described by David Musto in Chapter 2, drug use was almost equally divided among the advantaged and disadvantaged. Despite cocaine's status as the glamour drug of the 1970s and early 1980s, this pattern has radically changed. The National Institute of Justice Drug Use Forecasting (DUF) system administers anonymous urine screens to adult female and male arrestees in twenty-three major U.S. cities. Since 1986 the DUF system has provided the United States with the first objective measure of drug use among arrestees in major urban centers, and its findings clearly show that the spread of serious drug use is greatest in neighborhoods in which crime, unemployment, and lack of education create a vulnerable population.'

Dramatic declines in drug use reported in both the High School Senior and National Household Surveys exclude those people most likely to be drug abusers. The High School Senior Survey is highly publicized—although 50 percent of all arrestees never complete high school. Similarly, the National Household Survey

excludes not only the homeless but also all those who live in group quarters and institutions—including military installations, college dormitories, hotels, hospitals, jails, and prisons. DUF data further demonstrate that an "urban underclass" of drug-involved criminal arrestees in the sixty-one largest U.S. cities contains as many frequent users of cocaine (620,000 to 1.1 million) as are estimated to exist in the entire U.S. drug-using population as measured by the National Household Survey—which excludes this group.'

The tendency to underestimate the drug-using population prompts serious misperceptions within the public and may precipitate a premature victory celebration in the "war on drugs." At a time when raising taxes is politically unpopular, it may be tempting to turn away from disadvantaged drug abusers—the majority of whom belong to racial and ethnic minorities. To do this would leave these communities, already disadvantaged, with even fewer resources to combat the multitude of social ills that afflict them. Ignoring these problems over past decades has enabled poverty, illiteracy, infant mortality, teen pregnancy, child abuse, homicide, prostitution, and gang activity to grow to unprecedented proportions. Many of today's addicts are the children and grandchildren of those whose addiction and criminality were left unaddressed a generation ago.'

For these forgotten groups, it is inappropriate to think of drug "rehabilitation" programs. There is little in the experience of underclass addicts or of their communities that gives them a reference point for complying with middle-class norms. Social scientists are finding that the psychological profiles of inner-city U.S. children today are similar to those of children growing up in war-torn, Third World countries. The profiles reveal a lack of short-term memory, which, it is explained, is a psychological survival mechanism; the children learn to "erase" what is too painful to bear. Because drug abuse prevention, treatment, and research have focused on articulate white males, it is not surprising that U.S. officials find few weapons in the armory of models that have proven effective for unacculturated minority drug addicts—a population unaffected by the "just say no" campaigns of the 1980s. With few exceptions, drug treatment methods have not been developed for habilitation but for rehabilitation (or for pharmacological intervention and stabilization, as in methadone maintenance).

Publicly funded interventions for drug users can be divided into three major categories: outpatient methadone, residential' (including therapeutic communities), and outpatient drug free. To this should be added chemical dependency treatment, otherwise known as the Minnesota Model, which usually serves more advantaged addicts whose treatment is reimbursed by insurance. The two interventions used most frequently with underclass drug users are, methadone maintenance and therapeutic communities.

Methadone maintenance is designed for adults with long-standing dependence on heroin. Methadone treatment has the specific goal of reducing or eliminating the consumption of illicit drugs and concomitant predatory crime. In recent years it has also been applied to reducing needle use among heroin addicts, thus helping to

reduce AIDS-HIV transmission. Extensive studies show that when properly administered, methadone is effective in achieving those goals—and it is inexpensive compared with residential care.' But methadone is a limited tool. It is not suggested even by its most zealous proponents to be appropriate for nonopiate drug users (now the largest proportion of addicts) or for the youthful (often subteen) addict. Nor does it promote individual psychological development or community integration; rather, it stabilizes individuals and reduces criminal behavior.

Therapeutic Communities

From its inception, therapeutic community methodology has addressed the needs of criminally involved addicts and has recognized the need for habilitation, not just rehabilitation. The self-help therapeutic community (TC) for substance abuses originated in the United States through Charles Dederich, a former alcoholic and Alcoholics Anonymous (AA) zealot who in the 1950s inadvertently discovered that his brand of unorthodox and confrontational encounter groups caused some heroin addicts to stop using drugs. This discovery, coupled with an abundance of heroin addicts available to test the method, led to the establishment in 1958 of Synanon: a not-for-profit corporation that became the progenitor of therapeutic communities for drug addiction throughout the United States. Although Synanon's antipsychological stance and AA roots precluded scientific study of its members, it was soon clear that Synanon was having success in an area in which failure was the norm. At the time, conventional wisdom was "once an addict, always an addict." Synanon's claim that the most degraded and deviant members of society could live in a law-abiding, self-managed community and be the catalysts for their own recovery was—and remains—revolutionary.

Although acknowledging the absence of a medical "cure" for addiction, professionals showed little enthusiasm for Synanon's approach; they were especially skeptical of an addict's ability to reform without the benefit of trained psychiatric expertise. One exception to this thinking was Dr. Daniel Casriel (the first psychiatrist to visit Synanon), who proclaimed that there was now hope for those persons whose character disorders had made them the social outcasts of society.' The heroin crisis of the 1960s pushed public officials to provide funds for newly formed programs inspired by the Synanon Method.' Many such programs were started or staffed by ex-addicts who had been at Synanon, or by professionals such as Dr. Casriel of Daytop Village and Dr. Mitchell Rosenthal of Phoenix House."

In the past thirty years, the therapeutic community has become a major element in the effort to ameliorate the effects of drug use in the most disadvantaged populations. It is important to note that modern TCs, although rooted in Synanon, vary considerably from the Synanon approach.

The Synanon Approach

Syanon was an AA offshoot that rejected professionals and the medical-psychological approach to addiction and counseled the power of "self-reliance" in a self-help community. Its methodology of empowerment taught addicts to help each other out of their addiction, criminality, and other antisocial behaviors.

Although Synanon began with alcoholics and became famous for its work with heroin addicts, it never focused on drug addiction as its primary purpose; nor did it ever accept the notion that addiction was a disease requiring a professional cure. Its declaration of purpose stated that it was formed to research and investigate the causes of personal alienation—including but not limited to alcoholism, other drug addiction, criminality, and delinquency.' Many different people with all manner of compulsive behavior (gambling, eating, and the like) went to Synanon for help, and all behavioral problems were met with the same self-help-in-community approach. In 1970, for example, as the surgeon general's pronouncements about the health consequences of tobacco use became more forceful, Synanon members quit smoking en masse. Synanon's claim was that addicts gave up drugs as a "by-product" of actively engaging in a health-promoting community.

Syanon never directly accepted public funds. Although donations of cash and goods were actively and effectively solicited, Synanon's main income came from its own businesses; these grew to over \$20 million per year and were consistent with the self-reliance message. The only U.S. TCs to continue this approach are the Delancey Street Foundation in California and Habilitat in Hawaii. All other U.S. TCs are part of the publicly funded behavioral health care system, although some supplement their funds with other activities.

Syanon proudly flaunted its antiestablishment posture. There were many publicized battles with city councils, zoning commissions, licensing commissions, and probation departments and with the drug czars of the day—who were often appalled by the arrogant, pugnacious, racially integrated group of outcasts living together. Synanon's economic independence permitted it to make scathing public criticisms of the medical, treatment, and correctional establishments of the day with impunity. **But** as with present-day TCs, it formed a physical and psychological bridge between deviant underclass norms and the acquisition of mainstream social norms and behavior. Synanon prided itself 'on teaching hard work, honesty, parental responsibility, marital stability, and conventional morality.

But unlike the TCs of today, Synanon saw its role as much larger than merely the transformation of the underclass into hard-working, middle-class citizens. Synanon styled itself as a "model society" that demonstrated to the racially torn United States of the 1960s how blacks, whites, and Hispanics could live together in community; how the lawless could live lawfully without criminal justice supervision; how the dependent could learn self-reliance; how the irresponsible could become the compulsively responsible. This eventually led Synanon to stop blessing the

transition of its members back into mainstream society, which was seen as fundamentally unhealthy for those with addiction backgrounds.

The organization also purported to enable outcasts to speak with power brokers in a society in which social stratification prevented such contact. Many of the six thousand nonresident members were prominent professionals. All were involved in community outreach programs that used encounter groups between recovered ex-addicts and successful "squares" (nonaddicts) to promote a dialogue on morality and "right living." Dederich believed that reformed outcasts had a great deal to say to those in positions of power and privilege. Only when society accepted and integrated *all* its members, Dederich proclaimed, could it hope to achieve social health and social justice.

As with AA, there was no "staff" at Synanon. All were "members" who lived at the facilities, with varying degrees of status based on length of sobriety and achievement within the organization. Even fifteen years after its formation, with millions in assets, members drew no salary, but met their physical needs in a communal way. Dederich did not eschew U.S. capitalism—quite the contrary—maintaining a sense of community in which ex-addicts' therapeutic skills and community-building abilities were nurtured and respected. This differs from publicly funded TCs, in which staff are salaried and few, if any, live at the program site—thus introducing a "we" versus "they" distinction Synanon sought to avoid. This dichotomy is ameliorated somewhat by the regular recruitment of TC clients to become trainees and then staff members.

By the early 1970s, over 300 U.S. therapeutic community drug treatment programs could trace their origins to the Synanon approach. Synanon grew to have a residential membership of over 2,500 and a nonresidential membership of 6,000, with branches in nine U.S. cities and in Puerto Rico. Nonetheless Synanon began to decline in the mid-1970s and was out of business by the end of the decade."

TC Development in the United States

The therapeutic model derived from Daytop, Phoenix House, Odyssey House, and Gateway developed prominent characteristics:

- an institutional bias toward the treatment of male opiate addicts
- rigidity in structure
- relatively uncompromising discipline for program violations
- separation of residents from family influences (considered to be "negative")
- "on-the-job" training of ex-addict staff members
- hierarchical structure that equated clinical progress with moving up the ladder of program responsibilities
- a twelve- to twenty-four-month expected length of stay, with implicit acceptance of a very high dropout rate
- an antiscientific, antimedical orientation toward drug abuse

By the mid-1970s these characteristics had begun to change. Many TCs were larger and better established, and became part of the public health care system in the northeastern United States. Some began to successfully apply prevention programs to a broader version of the model—reaching out to adolescent substance abusers, polydrug abusers, clients under criminal justice supervision, addicted women with children, and school-age youngsters. Many TCs now have extensive family programs that bring their clients' families and "significant others" into the treatment process. In recent years more effort has been devoted to reentry programs. In many of these, continuity of care has come full circle by urging TC participants to join AA or Narcotics Anonymous (NA) fellowships.

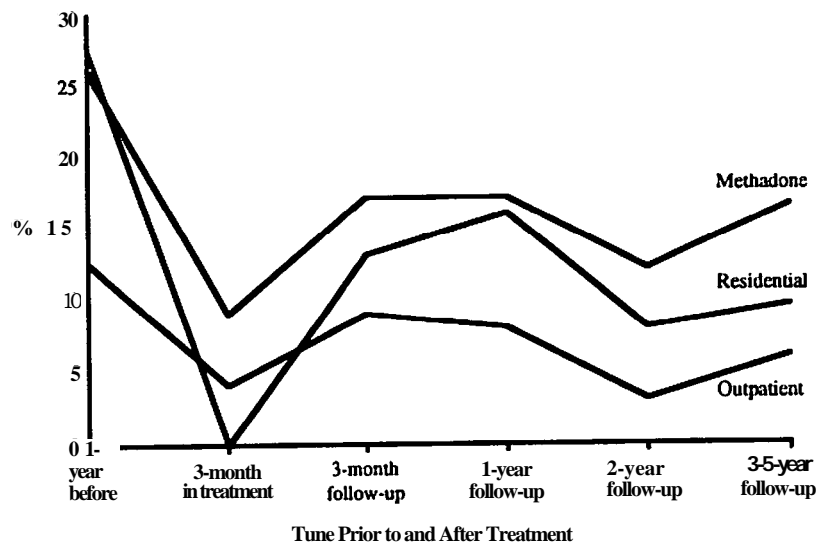
The most dramatic change, however, has been the introduction of public funding. With this funding came public scrutiny, audits, licensing by bureaucratic agencies, outside boards of directors, and constraints regarding who could be accepted for help. Public funding added the language of the medical and academic communities, in which the rehabilitative processes of community became translated into the medical terminology of drug abuse treatment. First "interpreted" by academics, psychologists, and physicians as a medical rather than a community approach, then controlled by the constraints of public funding, some of those involved with TCs became concerned about the loss of uniqueness and integrity. Some TC voices complained that the only model developed by the underclasses for the underclasses—the Synanon model—had been co-opted by the very groups that had been unsuccessful with addicts in the first place.

In general, TCs have come to emphasize group rather than individual therapeutic intervention. They stress firm behavioral norms with a system of clearly defined rewards and punishments within a communal economy of housework and other roles. They employ reality-oriented group and individual psychotherapy, which includes lengthy encounter sessions focusing on current living issues and deep-seated emotional problems. They impose a series of hierarchical responsibilities, privileges, and promotion of esteem through working up a "ladder" of tasks from admission to graduation—permitting some degree of mobility from client to staff member. Finally, they display an institutional bias toward underclass clients.¹²

Effectiveness of Treatment

Over the past quarter century, there have been two large-scale, federally sponsored treatment outcome studies: the **Drug Abuse Reporting Program (DARP)**, a twelve-year follow-up study of a national admission sample cohort of clients from 1969 to 1971," and the Treatment Outcome Prospective Study, a ten-thousand-person national cohort analysis of admissions to forty-one treatment programs between 1979 and 1981." Another large study is currently in progress. Principal findings to date demonstrate that

FIGURE 12-1
Prevalence of Regular Cocaine Use Before and After Treatment
(clients healed three months or longer)



Note: Percent = percent of patients treated using cocaine regularly.

Source: Reprinted, by permission of the publisher, from *Drug Abuse Treatment: A National Study of Effectiveness*, by Robert L. Hubbard et al., copyright 1989. The University of North Carolina Press, 109.

- Treatment reduces drug consumption and other criminal behavior for a substantial number of people; most do best while in treatment and do worse after treatment but are demonstrably better than before they entered treatment.
- Treatment is effective in all modalities, but effectiveness varies considerably among programs.
- Length of time in treatment is almost universally correlated with posttreatment success. (In fact, time in a program may be regarded as the one finding that has been nearly incontrovertible in drug abuse treatment studies. No matter what the treatment modality, those adults who stay in treatment longer almost invariably do better on all measures of posttreatment performance.)
- Benefits outweigh costs."

Treatment works and is cost-effective. However, "success" must take into consideration that relapse and several treatment episodes are often necessary to attain abstinence. A definition of success must also recognize that even when treatment does not achieve total abstinence, it often reduces drug consumption, criminality, and the social costs of addiction (see trend lines in Figure 12-1). If a hard-core

criminal addict becomes a casual user, there has been relative success—especially if an addict with a lifetime history of criminality and criminal justice supervision never goes to prison again. One 1989 study projected a public-sector gain of \$11.31 in benefits from each dollar spent on drug treatment.¹⁶

Therapeutic communities take more time and money than outpatient drug-free or methadone programs, but they realize greater long-term improvement when patients stay for at least a year. Even clients remaining three months show demonstrable gains. Not only is drug use substantially reduced but so is criminality—with dramatic improvements in psychological function, capacity for employment, stability of relationships, and community involvement." This is consistent with the TC outlook that drug abuse is merely one part of the problem. As one expert has explained, TCs regard drug abuse as the result of impeded personality development or accumulated deficits resulting from socioeconomic disadvantage and dysfunctional family background."

So few studies have been done of adolescents in TCs or other treatment modalities that results, although positive, are not authoritative. Generally, TCs have worked effectively with older adolescents whose admission profiles have not been substantially different from those of adults. Studies of women in TCs indicate that although most TCs have not been organized with women's needs as a priority, women have shown improvements during both treatment and posttreatment."

Research has yet to determine client characteristics that predict success, but studies show that unlike methadone maintenance programs, TCs can effectively serve participants who use a variety of different drugs. In the late 1960s, TCs treated a small but significant proportion of those using barbiturates, methamphetamines, hallucinogens, and cocaine. Studies at the time showed outcomes comparable for all drug users, thus anticipating the successful adaptation of TCs to primary cocaine users in the 1980s.²⁰

The major problem with TC treatment is retention. The DARP study showed that twelve months after admission, 71 percent of the clients had left treatment, although only 5 percent had completed their treatment plan.²¹ Although much more attention has been given to retention in the last decade, it remains the cardinal issue for treatment improvement and cost-benefit increases for TCs.

Prison Drug Treatment

The United States had over one million incarcerated persons in 1989, as shown in Table 12-1, and more than four million under criminal justice supervision (probation and parole)—more than any other nation in the world. The vast majority of these are drug abusers.²² The largest and most accessible population of addicts is in prisons and jails, and much of the demand for cocaine and other illegal drugs in the United States stems from the persons who are detained and supervised by the criminal justice system.²³ Retention is increased significantly when treatment is

TABLE 12-1
Federal and State Offenders Under Correctional Supervision, 1989

| Type of Supervision | Number in 1985 | Number in 1989 | % Change 1985-1989 | % of Total Under Supervision 1989 |
|--------------------------------------|----------------|----------------|--------------------|-----------------------------------|
| In the community | | | | |
| Probation | 1,968,712 | 2,520,479 | 28.0 | 62.2 |
| Parole | 300,203 | 456,797 | 52.2 | 11.3 |
| Totals | 2,268,915 | 2,977,276 | 31.2 | 73.4a |
| Incarcerated | | | | |
| Lail | 254,986 | 393,303 | 54.2 | 9.7 |
| Prison | 487,593 | 683,367 | 40.2 | 16.9 |
| Totals | 742,579 | 1,076,670 | 45.0 | 26.6 |
| Total under correctional supervision | 3,011,494 | 4,053,946 | 34.6 | 100.0 |

aPercentage figures do not add because of rounding.

Source: Based on data in L. Jankowski, "Probation and Parole 1989," *Bureau of Statistics Bulletin* NU-125833 (Washington, D.C.: Bureau of Justice Statistics, 1990), with adjustments in figures for total percentage changes 1985-1989.

initiated within an institution; compulsory treatment is as successful as voluntary treatment in most cases.²⁴

"Shock incarceration" or "boot camp"—type programs, widely embraced as a miracle cure during the 1980s despite the lack of evidence of their efficacy, have not been shown to reduce recidivism.²⁵ This is consistent with other indications that programs lacking treatment elements do not reduce recidivism rates of drug-involved criminal offenders. Treatment programs within institutions, by contrast, often lead to continuation of drug treatment in the community postrelease.²⁶ Additionally, segregating prison drug treatment programs from the general prison population and using ex-addicts as counselors (as well as other recognized TC methods) have demonstrably improved both institutional management of inmates and posttreatment results.²⁷ For example, two prison-based TCs, Stay'n Out (in New York) and Cornerstone (in Oregon), show significant reductions in recidivism and improvements in parole outcomes for program participants compared with a control group of untreated inmates.²⁸

It might be argued that the United States is the first industrialized country to attempt to incorporate incarceration as a bulwark in its approach to long-standing social problems.²⁹ Florida's Commission on Ethnic and Racial Bias projects that by 1994, 40 percent of all nonwhite males between ages eighteen and thirty-four will be incarcerated or under criminal justice supervision." Prison populations will continue to grow for some time. Politicians are sensitive to the moods of the voting citizenry, and it is probably fair to say that no U.S. politician has lost an election in the past fifteen years by being "too tough" on criminals and drug

when voting citizens begin to question the large expenditures and negligible results of the present approach will policy change.

Improving the TC: Amity Interventions

One current outgrowth of the TC movement is Amity, Inc.—a not-for-profit organization in Tucson, Arizona, that is a comprehensive therapeutic community model working with today's drug-using underclass. Amity operates facilities in three Arizona cities as well as a large prison-based TC in San Diego, California. Services include long-term adult and adolescent communities; adult and juvenile prison-based TCs; outreach, education, and prevention for youth, schools, and neighborhoods; AIDS prevention, education, and outreach; residential and vocational services for pregnant addicts and for addicted mothers and their children; and counseling and treatment for homeless substance abusers. Amity also has a nonresidential community center that serves as an alternative to prison for first-time offenders with drug histories and for probationers facing revocation because of drug involvement.

Organizational goals have been to respond to historically underserved populations and to develop pilot programs and community partnerships that apply the TC modality with other professionals involved with addicts (welfare, corrections, probation, health departments, neighborhood improvement, homeless shelters, and similar groups)." We describe four interventions that have improved the effectiveness of the therapeutic community model.

Responding to the Needs of Women

At the inception of publicly funded drug treatment in the 1960s, programs were designed for and run by men. They did not take women clients into account—especially women convicts, drug-using prostitutes, or pregnant teenagers. Female addicts have been considered sicker, more resistant to drug treatment, and more difficult to deal with than their male counterparts—or any class or ethnic group.

In 1974 the National Institute on Drug Abuse (NIDA) established a program for women's concerns. In 1976 Public Law 94-371 granted priority consideration to funding women's treatment programs (although children of addicts were not included in this initiative). NIDA studies showed that 70 percent of addicted women had been raped or molested prior to addiction. Another study showed that among street prostitutes, as many as 70 percent had been sexually abused as children and repeatedly raped as adults." Women drug users are disproportionately the victims of childhood sexual abuse, with estimates of sexual molestation as high as 60 percent (compared to 20 percent for men). Samples of treatment programs taken during the early 1980s indicated that the makfrity did not address issues of sexuality. In fact, drug-dependent women frequently reported sexual harassment within the program itself."

U.S. drug policy is beginning to recognize the needs of women, largely through extensive media coverage of the plight of "crack babies" and their addicted mothers. The need for treatment of pregnant addicts becomes more apparent to policymakers when they consider that the cost of care for a crack baby can easily exceed \$100,000 and that one year of special education for a drug-impaired third-grade child can cost \$13,000.⁴ "Only 12 female cocaine users sought treatment in Philadelphia 10 years ago," according to one newspaper account. "In 1989, there were more than 3,300. Today, nearly half the addicts in the city are women, and one in five babies born here last year had cocaine in their system." Female intravenous drug users—many of them prostitutes—are at high risk of becoming infected with HIV and spreading that infection to their sexual partners, to their needle-sharing partners, and to children through perinatal transmission.

Many of the adult drug users in the system today are children whose mothers were ignored by the system two decades ago. "In New York City," for example, "there are over 125,000 women seeking treatment of chemical dependency and the drug related problems of their infants and children. The number of pregnant women using cocaine during pregnancy has more than quadrupled between 1985 and 1990."⁵ The differences between treatment and prevention blur when intergenerational drug use and criminality become the norm, as they have in many underclass neighborhoods.

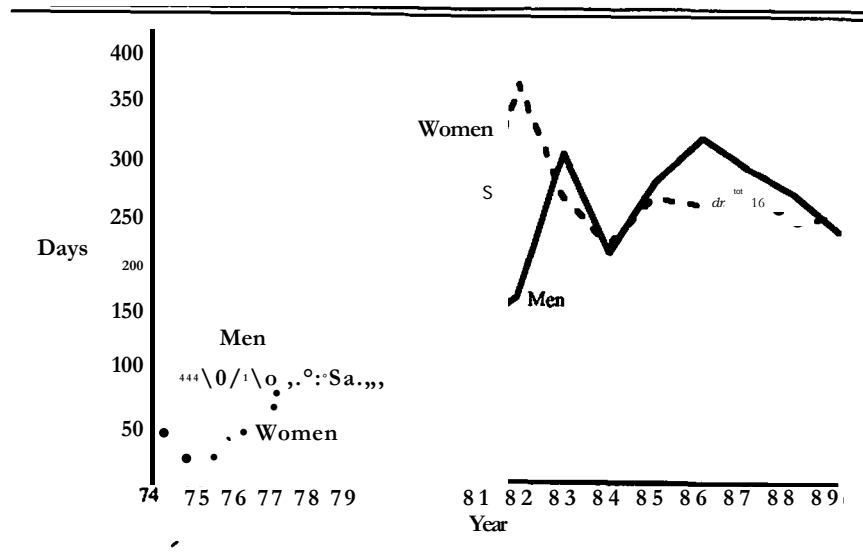
In 1981 Amity was a small (n =35) residential program with only one female resident. Although the planned duration of treatment was one year, the average length of stay for female residents had been forty-two days. Amity then introduced a series of changes:

- A female program director with ten years of TC experience was hired.
- Additional women staff members were hired until the ratio of female to male staff was 6:4.
- Special women's groups were held (as soon as there were enough women clients).
- Emphasis was placed both in the curricula and in daily activities on respect for women and on the importance of learning how to form nonsexual relationships.
- A small pilot project *was* started allowing women in duress to bring their children with them into the community.

Repeated surveys of women in treatment at Amity revealed that they averaged more than ten years of serious substance abuse over five years of prostitution and over two hundred sexual partners per year. Three-quarters had been molested or raped before age eighteen (the average number of rapes was six). For over half, Amity was the first attempt at drug treatment.

Results have been impressive. The proportion of women in treatment increased from 0.08 percent in 1981 to 32 percent by 1983. Length of stay increased for both women and men in spectacular fashion, as shown by Figure 12-2. The length of

FIGURE 12-2
Length of Stay at Amity, by Gender, 1974-1989



Note: Days = average length of stay, in number of days.

stay for the Amity adult TC is now roughly twice the national average for TC programs (which ranges from about 90 to 120 days). Women who were allowed to bring their children into the community successfully completed the program. Three years later, informal follow-ups showed that almost all were employed, that they were free from criminal activity or drug use, and that their children were functioning normally."

The dramatic change in retention suggests that meeting women's needs has a beneficial effect on all community participants. Carol Gilligan has observed that women's path to maturity differs significantly from that of men: Women almost always have the formation and maintenance of relationships as primary tasks. Gilligan also suggested that when women are given equality in community, they balance the more hierarchical and separatist tendencies of typical male development.⁶ The new model allowed women at Amity to feel physically and psychologically safe,⁷ and their own self-disclosure encouraged men to take similar emotional risks. Addicted men began to reveal histories of sexual molestation they had promised to "take to the grave."

Having a woman (a former addict) as the program director with a predominantly female staff positively affected both men and women. Women reported inspiration for their own personal growth; men reported security, with less need to challenge authority. Children's participation in the community also appeared to have a beneficial effect on men, who began to take a greater interest in their own children.

Many said that the presence of children changed their perception from being patients in "just another program" to being responsible participants in an extended family setting.

*Moving Toward Professionalism:
New Methods of Staff Training*

Drug treatment outcome studies have focused on client outcome, ignoring how staff—the most salient component of the treatment environment—affects retention, outcome, and perceptions of program participants. Substance abuse staff qualifications are moving rapidly toward academically trained and professionally certified counselors. There have been consistent efforts to develop a nationally recognized substance abuse credential. Over thirty states currently certify drug and alcohol abuse counselors. Often the credentialing of counselors is required for state licensing of programs; unlicensed programs cannot receive state funds.

Such training holds the promise of increased competency, reduced liability, professional advancement, and sophistication in the treatment of individuals with a diversity of problems and backgrounds. But little of the training offered in the field of substance abuse today helps staff members understand the constantly changing street culture. Even ex-addicts several years removed from the streets need to stay current with the acceleration of impairment. Available training does little to help academically trained and certified staff change perceptions by program participants that programs are just another institution populated by social workers making a living from the drug addict's misery.

Unfortunately, there is a tendency for professionals to see drug abusers as helpless victims. Low expectations are based on inadequate understanding. The original vitality of the TC approach depended on the perception of members that they had been accepted into a community—not a clinic. Living in the community were people whose life experiences, criminality, education, and racial and cultural characteristics were consistent with their own but who were behaving responsibly. High expectations were set by these credible role models, who knew the extent to which change was possible because they had changed themselves.

With publicly funded TCs the question becomes: Beyond recruiting and training former clients to become staff members, how can staff be trained to understand the community? How can "professionals" and ex-addicts become part of a community that recognizes the worth of each and develops shared values?

Amity introduced retreats for staff and residents in the mid-1980s. In addition to normal professional training activities, these eight-day retreats are held quarterly and usually include seventy-five to one hundred participants. All counseling staff participate in at least one retreat per year. Retreats are attended by staff (45 percent), residents (45 percent), and outside guests and program graduates (10 percent). Conducted by the most senior Amity staff, activities include encounter groups, outdoor experiences, art, family reconstruction workshops, and other experiential

and didactic workshops. The participants are completely emerged in curricula for the entire period, with no outside activities. Staff and residents interact throughout. Retreats emphasize and reinforce a sense of community, reduce social distance between staff and residents, and accelerate the transmission of vital information—in particular, about norms and mores in the rapidly changing street culture. Both residents and staff members regard retreats as a crucial intervention that keeps Amity feeling more like a community and less like a fragmented organization. Amity's high retention rate may reflect this approach. Adaptations of this model may be useful particularly for those who work with diverse racial and ethnic populations.

Drug Treatment in Jails

A National Institute of Justice study determined that whereas the average cost of incarceration is about \$25,000 per year, the average cost of crimes committed by each released inmate comes to \$430,000 per year in victim losses, police costs, court work, private security expenses, and other expenses. The director of the National Institute of Justice used the study to draw a confounding conclusion: "Public debate has mistakenly focused on the cost of imprisonment compared to the cost of probation," he intoned, and went on to urge further construction of prison beds rather than the adoption of effective treatment efforts.⁴⁰

Intensive drug interventions are scarce in federal prisons, but they are practically nonexistent in county or state jails. Of 1,687 jails participating in one survey, only 7 percent of the inmates were involved in some form of drug treatment—and that "treatment" might be as little as an occasional class with an overworked counselor or volunteer or a few videotapes. In fact, only 2 percent of the jails surveyed had more than ten hours per week of treatment activities—an effort that is completely inadequate for inmates who have extensive histories of serious drug abuse and assorted criminal problems. Information from the Drug Use Forecasting System indicates that at least 60 percent of inmates test positive for illicit drugs at the time of arrest.

Treatment in a jail or prison setting provides an important opportunity to engage offenders in a therapeutic environment with others who are experiencing similar difficulties. Many drug-involved offenders are unlikely to seek treatment on a voluntary basis and have a jailor record of treatment participation. Incarceration is frequently the first lengthy period of abstinence from drugs since initiation of regular drug use. Correctional treatment provides the opportunity to confront the inmate with the dear and unavoidable consequences of past drug use, to reduce the denial that often undermines involvement in treatment, and to develop life- and drug-coping skills in a structured and supportive milieu.!

Seeking to improve the situation in jails, Amity provided volunteer drug abuse services to inmates in the Pima County Jail for over five years. This project was designed by both organizations, each of which supplied senior staff members to jointly manage the project. Their supervisory team oversaw every aspect of the

program—from selection of participants to disciplinary matters to joint supervision and training of both jail and correctional staff. The sheriff's department recognized the value of Amity's trained ex-addicts and ex-offenders. The program featured an intensive curriculum that included regular encounter groups, week-long workshops on specific recovery-oriented topics, the use of video playback, participants working together in the jail's food services department, and structured community responsibilities in which participants took day-to-day responsibility for helping to manage the program under staff guidance. The program also emphasized continuity of treatment: Many participants made a transition to Amity's long-term residential services, others to other local treatment providers, and some to regular encounter groups jointly sponsored by Amity and the local probation department. Eventually, the jail program included day services for female offenders in the same unit as males. As with other Amity adult programs, the inclusion of women appeared to improve the environment for men by increasing self-disclosure.

After three years of operation, over four hundred jail inmates have participated in the Amity–Pima County Jail Project. Psychosocial measures given at intake, release, and six-months postrelease demonstrate significant improvements ($p < .01$) in levels of depression, anxiety, and self-concept for both males and females. These measures are found in other studies to be associated with stable reductions in drug abuse and improvements in prosocial functioning. Further, recidivism rates to substance abuse and rearrest are around 36 percent, which is very low for a short-term intervention. (Normal recidivism exceeds 65 percent.) Ninety-five percent of those successfully released from the program sought some kind of continued substance abuse treatment (residential, outpatient, AA, NA, or Amity-sponsored groups in the community). **For** many of these chronic substance abusers, this was their first treatment experience, and their efforts to continue treatment demonstrate changes in attitude about themselves and their responsibilities.⁴²

Addressing the Needs of Adolescent Addicts

Trends for adults are repeated with adolescents. Although relatively advantaged high-school seniors are turning away from drug abuse, there is evidence that abuse among the most disadvantaged may be increasing. More than adult treatment, adolescent treatment has been aimed at youth who are acculturated, verbal, and oriented toward middle-class society. Few public or private organizations have devoted sufficient resources to alienated, drug-involved, violent teens. With the turn toward harsh punishments for juvenile offenders in the 1980s, more teens were tried as adults and social services were proportionately less available. At the same time, the continued rapid decay of inner cities and the advent of crack left advocates completely unprepared for the underclass teen of today. Like adults, teens are disproportionately incarcerated and experience social bias: **According to the Florida Supreme Court Racial and Ethnic Bias Study Commission**, "Minority

youth." Criminal justice intervention with teens is a predominant method of dealing with deviance, and rehabilitative resources are rarely available."

Today's disadvantaged drug-using teenager is quite different from his or her peer of only ten years ago. Typically black or Hispanic, the contemporary teen is much more likely to come from a home in which one or both parents have substance abuse histories and involvement in the criminal justice system and in which the family is chaotic, poorly organized, impoverished, and abusive; the teen has probably been a victim of physical or sexual abuse in childhood and in all likelihood began using alcohol, drugs, or toxic vapors under ten years of age and became addicted by age thirteen. Girls are likely to have been sexually active before reaching puberty, to have been raped or molested, and to have had children or an abortion. Male or female, the teenager may have had experience as a prostitute (for sex, for drugs, for food and shelter, or for companionship), and if male, has probably been involved in several rapes—sometimes gang rapes. He or she has probably never had sex without being "high."

Often, the drug-abusing teenager began getting involved with the criminal justice system very early—perhaps before becoming a teen. The prospect of arrest, detention, or incarceration is not especially frightening; jail may be safer than the streets. Additionally; the teen is probably involved in gang activity and has been a drug distributor and drug dealer.*

The availability of crack cocaine has changed the street scene in ways few public officials understand. Overnight, poor and vulnerable children became victims of a drug that is inexpensive, easily available, ten times more potent than the heroin that created the heroin scare in New York in the early 1960s, and more addictive than any drug of modern times. In neighborhoods in which even \$3 "rocks" of crack were too expensive, children continued to use gasoline, marijuana laced with PCP, spray paint, and other toxic substances. Despite the overwhelming media coverage of crack, few outside the immediate scene have any familiarity with the devastating violence and sexual promiscuity young women experience in crack houses in inner-city neighborhoods.*

Amity has worked closely with the **Arizona** Department of Juvenile Corrections since the mid-1980s to **develop** a comprehensive model for youth that begins in juvenile correctional institutions, Moves to **communitybased residential care**, **then** to transitional homes and aftercare. This intensive model is based on the premise that these teenagers are developmentally arrested and that they have not had the environment, circumstances, or encouragement to develop a less deviant value system. This model assumes that several months and perhaps years of a modified therapeutic community regime are necessary for teens to acquire the attitudes and skills that will enable them to live successfully. It further assumes that without successful intervention, these youth **are** the next generation of adult drug-using criminals—ready to spend their lives in and out of police stations, courts, jails, and prisons.⁴⁷

Working with such youth requires discretion and sensitivity. They are physically mature, street smart, and hardened beyond their years. At the same time, they are emotionally immature—often illiterate, frightened, and naive about the world beyond the barrio and the detention center. As modified for the special needs of these youth, the TC provides an intensive 24-hours-per-day, 365-days-per-year holistic learning environment; a focus on family resources; and a curriculum that includes academic instruction at grade level, prevocational and vocational training, encounter groups and workshops to improve ability to express and control feelings, learning skills of cooperation with peers and adults, learning how to build and maintain positive peer networks, and supportive adult relationships. Transition homes, aftercare support, and relapse prevention help ensure that gains made in treatment are supported and strengthened after treatment. There is also a particularly rare opportunity for young women to participate in a community that includes both adolescent and adult addicts who are mothers learning to become effective and caring parents.

The development of this model is based on several years of cooperation between the Arizona Department of Juvenile Corrections and Amity. Evaluation of the program remains to be done, but the development of a working relationship between a private drug treatment agency and a public correctional agency is an important accomplishment. This joint venture targets youth who are 60 percent nonwhite and come from barrios, ghettos, and native American reservations in Arizona. The project offers an opportunity for these youths to learn skills and attitudes that can help them change their headlong rush toward criminality and continued incarceration as adults.

Whatever the final outcome of the Arizona-Amity program, the problems of youth pose a central challenge to U.S. society. As C. Ronald Huff has written:

Youth gangs are symptomatic of many of the same social and economic problems as adult crime, mental illness, drug abuse, alcoholism, the surge in homelessness, and multi-generational "welfare families" living in hopelessness and despair. While we are justly concerned with the replacement of our physical infrastructure (roads, bridges, sewers), our human infrastructure may be crumbling as well. Our social, educational, and economic infrastructures are not meeting the needs of many children and adults. Increases in the numbers of women and children living in poverty (the "feminization" and "juvenilization" of poverty) are dramatic examples of this recent transformation.

To compete with the seductive lure of drug profits and the grinding despair of poverty, we must reassess our priorities and reaffirm the importance of our neighborhoods by putting in place a number of programs that offer hope, education, job skills, and meaningful lives. It is worth the cost of rebuilding our human infrastructure since it is, after all, our children whose lives are being wasted and our cities in which the quality of life is being threatened."

The decline in casual drug use can be the occasion for the United States to abandon its costly and generally ineffective efforts to use law enforcement and punishment as its bulwarks for demand reduction in the campaign against drug

abuse. If the United States turns toward its underclass drug abusers, models that have been successful in the habilitation of such users should play an important role in building bridges out of the barrio and ghetto and into productive roles in society. This is not possible without addressing all the needs of these disadvantaged drug users. It makes little sense to provide drug abuse treatment for the impaired native American when, at the end of treatment, the oppressive poverty and hopelessness of the reservation remain. We will not be successful in intervening with the pregnant addict if there is no way for her to provide adequate shelter, nutrition, and health care for herself and her child or children during and after treatment. Nor is it effective to use methods that call for one-on-one interventions with underclass drug users. Instead, community and institutional intervention methods, such as adaptations of therapeutic communities, can be used to transform penal institutions into habilitative centers and underclass neighborhoods into healthy communities.

Implications for Latin America

Latin America, now addressing its own internal drug consumption and abuse problems, has much to learn from mistakes made in the United States. Rather than squandering limited economic and social resources on drug interdiction and relying on law enforcement to reduce demand, Latin America can begin to build effective programs and the social infrastructure for healthy communities. Latin America must not, like the United States, ignore its socially disadvantaged—including the millions of abandoned children and the poor who have turned to *basuco* and toxic inhalants. South American countries should not expect medically inspired models designed for less-pressing problems of middle- or upper-class educated clients to help those—as in U.S. urban areas—for whom addiction begins in childhood and who are poor, illiterate, hungry, and hopeless.

Using Models Applicable to Similar Populations

Underclass neighborhoods in Rio de Janeiro, Bogota, or Lima may not be that dissimilar from the desolate ghettos of Newark, Philadelphia, and Chicago; the gang-controlled barrios of Los Angeles, Houston, or New York; or the impoverished and alcohol-devastated native American reservations of South Dakota and Arizona. In 1987, for example, 60 percent of female-headed families in the United States lived below the poverty line. Forty-five percent of all black children and 39 percent of all Hispanic children are living in poverty. Black men over age eighteen are the only group in the United States for whom life expectancy is consistently dropping, with murder being the most frequent cause of death." In the United States, children are more likely to live in poverty than any other social group.

Treatment methods that are effective in devastated and penurious environments in the United States may have the greatest promise for successful adaptation for similar populations in Latin America. Latin American countries need to understand that the TC model can be applied in a much broader manner than it has been in

the United States, where it is identified with adult hard-core drug addicts. The model can be adapted to serve pregnant addicts, provide a rehabilitative community for abandoned children, serve the homeless, and work in the criminal justice system with drug-using offenders. Furthermore, origins of the model show that it need not be limited by exclusive reliance on public funds. Therapeutic community interventions can develop their own self-supporting (or self-supplementing) economic enterprises, which make them less expensive and more replicable. Adaptations of these types of economically self-reliant TCs can be found throughout the world, including both agricultural and industrial TCs in Scandinavia and Europe.

The family structure of Latin American countries may be more amenable to involvement in drug abuse treatment. Such is the case in Italy, where adaptations of the U.S.-born therapeutic community have a pretreatment phase involving the entire family. During treatment family members participate actively, and retention is as high as 80 percent. Treatment programs and community mobilization efforts in Latin America should explore whether the needs of women are being met. Meeting these needs may improve the ability of an organization to become a real community, which is the environment most restorative of human values. Modifications of this model may have some relevance for jurisdictions in South America in which abandoned children left to their own devices are increasing in number and in deviance. The use of therapeutic community methodology to build communities where children can live in a stable environment that provides safety, shelter, food, and the conditions for normal development can be a cost-effective method for addressing these problems.

Avoid Punishment as the Paramount Solution

Latin America must not rely on criminal justice sanctions to solve drug demand. These countries cannot afford the folly engaged in over the past decade in the United States with its massive prison construction campaign to incarcerate drug-abusing criminals. Social deviance must be attacked at its roots in the disenfranchised and impoverished communities that are outside the social and economic life of the society. Beyond rebuilding the social and economic infrastructures of these communities, attention should be given to rehabilitative programs and community efforts that address the developmental and social deficits of underclass drug users. For those who have become criminally involved, the U.S. experience teaches that incarceration alone does not reduce drug abuse and its attendant criminality. Only intensive long-term interventions with criminal addicts in highly structured community-based programs or while incarcerated will reduce criminal recidivism.

Final Thoughts: Drug Users as Toxic Waste

Criminality and drug abuse are as much by-products of modern U.S. social practices as toxic waste is an expected by-product of modern industry. Postindustrial

society is synonymous with the breakdown of community, neighborhood, and family. This has led to the disintegration of the crucible in which the values we recognize as human are formed. We have reached a point in the United States where the term "underclass" is acceptable; we have large numbers of people who do not feel part of society, who take no responsibility for that society, and who are harmful, or "toxic," to it.

For years, we dumped our industrial toxic waste and ignored any possible consequences; rivers were poisoned, ground polluted, air saturated with toxins. When there were major and visible accidents—Love Canal, the Exxon spill—we paused and moved briefly beyond the veil of denial and acknowledged the real cost. Many areas will never be restored to their original purity, yet pollution continues. It is considered too expensive to take steps to control pollutants. When the garbage is not visible, society is not concerned.

As with toxic waste, drug users attract little community attention when they are out of sight. Whether through incarceration, homelessness, or lack of advocacy, they are forgotten until their toxic properties begin to cause harm. The majority of those incarcerated come back into society; homeless children grow into gang members then become violent adults; intravenous drug users spread AIDS—as with toxic waste, they all bring harm. We begin to comprehend the true cost when we follow drug users through their wasted lives; through their criminal activities, their lost productivity; their arrests, trials, and incarcerations; their illegitimate, abandoned, and abused children. Like the ports that refused entry to the infamous garbage barge from New York City, no neighborhood or community wants drug addicts or offenders of any age near it whether they are actively addicted, in prison, or in a treatment setting. They are considered toxic—like garbage, never to be brought back into the home.

For decades the United States has not demonstrably changed its methods with its "toxic" population. The pollution spreads, causing heretofore unheard-of mutations. What has been the cost of not investing in breaking the cycle of addiction? Can we afford that price? Treatment begins the process of change from being toxic to inert and, at best, useful. Buckminster Fuller once stated that the problem with smog was that it represented energy in the wrong place; Ralph Waldo Emerson observed that a weed was a plant whose virtue had not yet been discovered. Both analogies are applicable. The most powerful and seasoned warriors in the so-called drug war may be the recovered wounded. Lewis Yablonsky views TC graduates as assets that in a sense are antibodies in the overall social system who have been immunized against substance abuse. They provide a kind of social vaccine for the overall social system. The explosive development of therapeutic communities has produced a social vaccine that if properly applied, increasingly can significantly reduce the international substance abuse problem.⁵⁰ TC graduates, who have addressed addiction through whole-person education, have addressed their own toxicity—their own problems with violence, irresponsible parenting, unhealthy relationships. If each graduate could successfully "inoculate" five afflicted individuals, we could witness large-scale

community recovery. Let us not discard this population as a toxic waste. Let us regard **its presence as a resource** and an opportunity.

Notes

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3. In the 1965-1975 period, federal support boosted the development of the publicly funded tier of drug treatment, but during the following decade federal support was drastically reduced. Although individual states were expected to pick up the costs of programs, overall support dropped. When public attention again focused on drug abuse in the mid-1980s, newly appropriated funds were directed mainly toward drug traffickers and prevention among nonuser groups.
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5. Because the *term therapeutic community* is almost universally misused and misunderstood, it is important to distinguish this type of therapeutic community from the totally independent and very efficient programs (pioneered by Maxwell Jones) that democratized mental hospitals in England. Jones's therapeutic communities have had a wide influence in mental health treatment and to some extent have influenced substance abuse treatment, particularly in Europe.
6. Daniel Casriel, *So Fair a House: The Synanon Story* (Beverly Hills, Calif.: Book Company of America, 1965), 457-473.
7. Lewis Yablonsky, *Synanon: The Tunnel Back* (Baltimore: Penguin, 1965), 3-25.
8. Lewis Yablonsky, *The Therapeutic Community: A Successful Approach for Treating Substance Abusers* (New York: Gardner, 1989), 36-41.
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10. Unlike Synanon (which stopped having graduates from its programs in 1967), Delancey does have program graduates. Its recommended length of treatment exceeds that of other publicly funded TC programs.
11. Synanon began to define itself by the late 1960s as an alternative model society that would show the world how to solve the problems of drug addiction, racism, family disintegration, and the like. However, Synanon's ex-alcoholic founder Charles Dederich began drinking again in the mid-1970s and was subsequently charged with and convicted of deadly assault against an attorney who was suing Synanon. Synanon stopped working with addicts, declared itself a new religion, became widely discredited as a cult, and lost its tax-exempt status; it no longer exists.

12. Gerstein and Harwood, *Treating Drug Problems*, 154-156.
13. S. B. Sells and D. D. Simpson, "Evaluation of Treatment Outcome for Youth in the Drug Abuse Reporting Group (DARP): A Follow-up Study," in G. M. Beschner and A. S. Friedman, eds., *Youth Drug Abuse: Problems, Issues, and Treatment* (Lexington, Mass.: D.C. Heath, 1979), 1-14.
14. Hubbard et al., *Drug Abuse Treatment*, 43-55.
15. Gerstein and Harwood, *Treating Drug Problems*, 134-136.
16. *Treatment Works: The Tragic Cost of Undervaluing Treatment in the "Drug War": Executive Summary and Highlights* (Washington, D.C.: National Association of State Alcohol and Drug Abuse Directors, 1989), 1-5.
17. W. S. Condelli, "Client Evaluations of Therapeutic Communities and Retention," in George DeLeon and J. T. Ziegenfuss, eds., *Therapeutic Communities for Addictions* (Springfield, Ill.: Charles C. Thomas, 1987), 131-139; George DeLeon and Nancy Jainchill, "Male and Female Drug Abusers: Social and Psychological Status 2 Years After Treatment in a Therapeutic Community," *American Journal of Drug Abuse* 8, no. 4 (1981-1982): 465-497; George DeLeon, *The Therapeutic Community: Study of Effectiveness* (Rockville, Md.: National Institute on Drug Abuse, 1984), 21-29; George DeLeon, "The Therapeutic Community for Substance Abuse: Perspective and Approach," in DeLeon and Ziegenfuss, *Therapeutic Communities for Addictions*, 5-18; George DeLeon, "Psychopathology and Substance Abuse: What Is Being Learned from Research in Therapeutic Communities," *Journal of Psychoactive Drugs* 21, no. 2 (1989): 177-188.
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