CHAPTER 1

Background and Overview of the Target Cities Demonstration Program

Christy K Scott
and
Randolph D. Muck

This volume is an effort to describe the experiences and results of a large, federally funded substance abuse research project known as Target Cities, which was designed to address a multitude of challenges inherent in the country's approach to treating substance abuse. These challenges included poor treatment infrastructure, accessibility, and quality; service provider capacity; service coordination/integration; and treatment outcome monitoring. Undertaken in 10 cities across the United States, Target Cities projects were funded through the Department of Health and Human Services (DHHS) and its Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is the federal agency charged with improving the quality and availability of mental health and substance abuse treatment and prevention services in the country. Federal funding for the Target Cities projects was made available through SAMHSA's Center for Substance Abuse Treatment (CSAT).

At the project's outset, CSAT's administrators recognized that drug and alcohol abuse was a complex, multifaceted phenomenon that impacted on a wide variety of areas in a person's life, including physical and mental health, family relationships, employment, involvement with the criminal justice system, and housing, as well as other domains. Many treatment facilities across the country were not equipped to deal with the myriad of problems. Accordingly, CSAT issued a call for proposals (e.g., a Request for Applications [RFA]), which invited both public and private substance abuse treatment agencies to design new paradigms for assessing and treating persons struggling with substance abuse (U. S. Department of Health and Human Services [DHHS], 1990).

The specifications for the creation of the Target Cities projects contained a number of elements (which will be discussed in detail later in this chapter). However, the key components required of each applicant site were a management information system, a standardized assessment process that would include a paradigm to match participants to appropriate treatment facilities, case management services, linkages with agencies across the community whose services could be utilized by Target Cities participants, and both process and outcome evaluations of these efforts.

CSAT funded Target Cities programs in two separate waves. This book addresses the efforts of the 10 Target Cities programs funded in the final wave. Unique to this generation of Target Cities was the fact that, in addition to local evaluation efforts, there was also a multisite evaluation that culminated in large multisite databases containing information for thousands of individuals. This book includes studies that utilize both multisite and local site data to address the fundamental questions regarding the success of the Target Cities effort.

Even though the multisite databases have been used primarily to evaluate specific components of the Target Cities experience, it is important to note that these databases provide one of the richest sources of data on drug and alcohol users in the country. Detailed information is available on over 40,000 cases in the databases. Several research questions, including many that are not related to the Target Cities Program's concerns, can be investigated using this extremely valuable set of data.

Prior to examining the results of this project, it is important to place the Target Cities initiative in a historical context that outlines the increasingly complex and sophisticated evolution of the ways in which problems of drug and alcohol abuse are, and have been, addressed in this country.

The Evolution of Drug Treatment Policy

Several concerns regarding addiction treatment in the United States led to the initiation of the Target Cities Program—treatment agencies' financial and organizational infrastructure, service accessibility, quality of clinical practice, intra- and interfield collaboration, and outcome monitoring. The following discussion briefly outlines the evolution of these concerns and describes the social policy context within which the Target Cities Program was initiated.

Following America's "discovery" of addiction in the late 18th and early 19th century (Levine, 1978), the definition of alcohol and other drug-related problems emerged for the first time as a newly christened medical disorder: *inebriety*. A private network of inebriate homes, inebriate asylums, and private addiction cure institutes emerged in the second half of the 19th century. Many of these institutions were linked through their membership in the American Association for the Study and Cure of Inebriety (Baumohl & Room, 1987). Even at the height of their popularity in the 1880s and 1890s, inebriate institutions were plagued by problems of weak organizational infrastructures, inadequate funding, geographical and financial inaccessibility, inconsistent and even harmful care, and poor continuity between the initiation of recovery in an institutional setting and transfer of that recovery process to natural community environments. Problems of poor service coordination (particularly between inebriety and psychiatric institutions) and lack of continuity of care were pervasive and spawned proposals for the creation of what today would be called a "continuum of care" (Crothers, 1893). These proposals for federal and state involvement in the planning, financing, and regulation of inebriate asylums in the 19th century were never fully implemented or sustained. Support for addiction treatment rapidly dissipated in the opening decades of the 20th century as the country fell under the sway of a series of anti-alcohol and anti-drug campaigns that focused, not on helping the victims of drug addiction, but on legally prohibiting and/or controlling access to psychoactive drugs (White, 1998).

The dramatic policy changes brought on by the passage and interpretation of the Harrison Tax Act of 1914 and the passage of the Eighteenth Amendment to the Constitution in 1919 led to the virtual demise of most addiction treatment institutions in America. Most private and state-operated inebriate asylums closed. Brief (1919–24) local experiments in morphine maintenance were terminated under threat of criminal indictment, and access to addiction treatment existed only for the most wealthy within a shrinking pool of private hospitals and sanatoria (White, 1998). Viewing addiction as a criminal rather than medical problem led to the transfer of responsibility for these problems from physicians and hospitals to law enforcement and criminal justice institutions.

Two treatment trends emerged in post-Prohibition America: (a) the first federal involvement in addiction treatment via the opening of two federal prison hospitals for narcotics addicts in Lexington, Kentucky (1935), and Fort Worth, Texas (1938), and (b) a multibranched

"modern alcoholism movement" that sought local, state, and, eventually, national involvement in the establishment of community-based alcoholism treatment services.

These two trends reflect the split in social policy toward dealing with alcoholism and narcotic addiction that followed the repeal of Prohibition. Addicts were isolated from the community in prisons and punished, while at the same time new calls emerged for the provision of community-based alcoholism treatment. The incarceration of narcotic addicts escalated dramatically in the late 1920s and 1930s, which led to increased calls for treatment inside the Federal Bureau of Prisons and subsequent opening of the prison hospitals in Lexington and Fort Worth through the U.S. Public Health Service. In contrast to this policy was the opening of hospital-based alcoholism treatment units in cooperation with local Alcoholics Anonymous groups.

There were also problems with the lack of continuity of care that characterized both the treatment of alcoholics and narcotics addicts. A perennial problem of the U.S. Public Health Hospitals in Lexington and Fort Worth was the lack of continuity of care that resulted from trying to treat addicts hundreds or even thousands of miles away from their local communities. These concerns eventually spurred experiments in establishing reentry clinics in communities such as New York and Detroit. Marty Mann, a pioneer organizer and researcher in this field, sought to bridge this gulf between the alcoholism treatment institution and the community when she announced the creation of the National Committee on Education on Alcoholism (NCEA) in 1944 (Mann, 1944). Mann called for the creation of

- local hospital detoxification units;
- local alcoholism education, assessment, and referral centers;
- local alcoholism treatment institutions; and
- "rest homes" for those who needed extended convalescence and rehabilitation.

Mann's proposals reflected concerns not only to create treatment resources but to guarantee that such services met standards of quality and accessibility and that such services were coordinated to assure some degree of continuity of care between the elements of what she conceived as a service "system." The service elements proposed by Mann increased in the 1940s and 1950s—most under the

leadership of local NCEA affiliates or through the private actions of members of Alcoholics Anonymous. In spite of the building blocks of a treatment system, Mann's vision of a community-based continuum of care for alcoholics went unfulfilled in most communities until the 1970s.

New local community–level treatment models emerged in the 1950s and 1960s that could be replicated in communities across the United States: outpatient clinic models and the residential-based Minnesota Model for treating alcoholism, therapeutic communities and methadone maintenance for the treatment of narcotics addiction, and outpatient drug-free counseling as a treatment for the growing problem of youthful polydrug abuse. What was needed was a shift in policy that would allow for the wide replication of these new treatments.

In the 1950s, reports from joint committees of the American Medical Association (AMA) and the American Bar Association (ABA) recommended that responsibility for the country's drug problem should be shifted from the criminal justice arena to the medical and public health venues. The AMA/ABA reports called for a renewed emphasis on treatment and medically directed maintenance experiments for narcotics addiction. The 1967 report of the Cooperative Commission on the Study of Alcoholism went even further in outlining the skeleton of what would become the federal-state-local partnership in the management and treatment of addiction (Plaut, 1967).

This groundwork led to growing federal and state involvement in addiction treatment in the 1960s and the passage of legislation in the early 1970s that virtually spawned the modern field of addiction treatment. The creation of the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse marked a major turning point in more than a century of efforts to address the problem of addiction. Between 1965 and 1975, the federal government, through new funding initiatives, established a national network of *local community–based treatment programs.* This shift reflected the movement toward more medicalized models of addressing narcotics addiction and was also fueled by the Nixon administration's concern about the rise in drug-related crime. This change included some experiments with Centralized Intake Units (CIUs), a single point of entry into the treatment system (e.g., Special Action Office for Drug Abuse Prevention [SAODAP], 1974).

President Nixon recruited Dr. Jerome Jaffe in 1971 to head SAODAP. Jaffe had previously been in charge of a pilot program in Chicago to respond to increasing numbers of heroin addicts. In an effort to streamline the service delivery system to deal with the increasing

problem, Jaffe had overseen the development of a single point of access model wherein an assessment (including a physical examination) was performed and clients were matched with appropriate treatment programs. Jaffe brought this model of CIUs with him to SAODAP. Shortly after Jaffe's arrival, contracts were issued for cities to set up CIUs and systems similar to the model developed in Chicago (Scott, Muck, & Foss 2000; Massing, 1998).

As a part of the federal war on drugs, treatment capacity was increased exponentially. By 1973 some cities had excess capacity. However, during the 1980s support for treatment services declined, and the focus of federal efforts shifted to law enforcement and interdiction. Drug enforcement budgets were increased by 20%, and treatment funding was reduced by 25% (Besteman, 1990).

Although the 1970s saw an increase in funding for treatment, and the federal government was influencing the start-up of CIUs across the country, there was little data produced on how well these systems actually worked. CIUs, while gaining popularity, did not have scientific findings that supported their existence.

In concert with the reduced federal funding, the voices that opposed CIUs, mainly local treatment providers, began to be heard. Any funding for a CIU would take away from the dollars available for treatment programs. CIUs, where they existed, held the decision-making authority regarding which programs clients were referred to. Consequently, by the late 1980s, CIUs were shuttered and closed in almost all jurisdictions.

A large multimodality treatment system had emerged in the late 1960s and early 1970s, even as concerns were raised anew about problems of weak infrastructure, inconsistent quality, poor accessibility, and a lack of service coordination and continuity. These concerns were magnified as federal spending for drug treatment diminished between 1975 and 1986. Although some states attempted to supplant federal funding, the availability and quality of treatment varied widely across the country. The bottom line was a sharp decline in the stability of the community-based public tier of treatment, paralleled by a period of unprecedented growth for the role of the criminal justice system during the 1980s. This intensified criminalization of addiction in the public sector was paralleled by growth in the private addiction treatment sector. The private sector embraced the medical ideas about addiction, leaving few resources for those dependent on publicly funded substance abuse treatment.

In 1990, the Institute of Medicine (IOM) published a report that summarized this period, noting that the public tier of drug treatment

had been the neglected front in the drug wars of the 1980s. The report further highlighted the way in which the federal anti-drug abuse legislation of 1986 and 1988 directed funding toward enforcement against traffickers and prevention among nonusers. Publicly funded substance abuse treatment was largely ignored, with the exception of treatment related to stemming the growing epidemic of acquired immune deficiency syndrome (AIDS).

There were a number of trends that emerged related to the state of addiction treatment in the 1980s that laid a foundation for the Target Cities Program. First, many treatment agencies were plagued by weak organizational infrastructure, by clinicians' preferences for particular types of treatment or specific treatment agencies, by isolation from the larger network of health and human service providers, and by clinical practices that did not reflect the latest breakthroughs in clinical scientific research.

Second, there was a growing recognition of subpopulations of participants and "special populations" as shifts occurred in primary drugs of choice (from heroin to crack cocaine) and as clinicians came to believe that treatment methods needed to be adapted to the user's age, gender, culture, and developmental history. The drug-related spread of HIV and the growing numbers of persons with AIDS seeking treatment added further urgency to the need to address multiple and complex problems within addiction treatment institutions. The shift from providing a "program" for all participants to a greater emphasis on differential diagnosis and individualized treatment planning created enormous pressure to elevate the level of clinical practice in most treatment agencies.

A third trend in the 1980s was the growing complexity of the clinical profiles presented by participants seeking treatment. Increasing numbers of those seeking addiction treatment presented with multiple problems of great chronicity and acuity and with complicated service histories in multiple systems. Shifting social policies brought ever-increasing numbers of substance abusers into both the criminal justice and child protection systems and generated an enormous flow of referrals to treatment. The recognition that these participants had long histories of exclusion, extrusion, premature service disengagement, and multiple service episodes across many community agencies generated incentives toward increased agency coordination in the short run and visions of integrated service systems.

A fourth trend in the 1980s was that rewards were beginning to be reaped by the nation's investment in addiction research. Research findings were beginning to underscore some basic principles of what

worked in treatment, and new treatments were emerging from pharmacological adjuncts to empirically based, manual-guided therapies. These advancements threatened to further widen the gap between the advances of addiction science and the state of clinical practice in mainstream addiction treatment in the country.

The Interface between the Institute of Medicine, the Office of Treatment Improvement, and Target Cities

The Anti-Drug Abuse Act of 1986 called upon the Secretary of Health and Human Services to commission an independent study of substance abuse treatment. This landmark study conducted by the Institute of Medicine was published under the title *Treating Drug Problems* and led to significant changes in the focus of federal treatment-related activities. These changes included the establishment of the Office of Treatment Improvement (OTI), which later transitioned to the Center for Substance Abuse Treatment (CSAT).

The public tier of addiction treatment began to expand following the passage of the Anti-Drug Abuse Act. Treatment expanded even more dramatically through resources provided under the 1988 Anti-Drug Abuse Act and the emergency supplemental appropriation to the Alcohol, Drug Abuse, and Mental Health Services (ADMHS) block grant in 1989. The Office of National Drug Control Policy (ONDCP), which was legislatively authorized and established in March 1989, was assigned a leading role in national strategic planning for drug treatment. Approximately 6 months later, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) consolidated the block grant and many of the treatment demonstration authorities in the Office of Treatment Improvement.

The general mission of the Office of Treatment Improvement was to improve the overall quality of drug abuse treatment nationwide. Coordination among local, state, and federal agencies was a major theme within the OTI treatment improvement strategy. Moreover, the IOM report, *Treating Drug Problems* (Gerstein & Harwood, 1990, p. 195) clearly recommended that the "National Institute on Drug Abuse, in conjunction with its sister agency, the Office of Treatment Improvements [*sic*], needs to give more adequate, focused attention to the drug treatment delivery system as a whole." To that end, part of the rationale underlying the OTI philosophy for improving treatment was outlined in the *Target Cities Demonstration Program Request for Applications*. This document communicated the need for a comprehensive

service system, including centralized intake, in which participants were objectively matched to the most cost-effective treatment, case management, coordination, and outcome monitoring.

The model or philosophy outlined in the Target Cities Program was consistent with concurrent work by the Institute of Medicine (Gerstein & Harwood, 1990) that recommended a comprehensive self-correcting system of care that included assessment, matching, outcome determination, feedback, continuity assurance, and clinician training.

Overview of Target Cities

Through the Target Cities demonstration project, a total of 19 cities were funded in two 5-year waves. The first wave of cities included Albuquerque, Atlanta, Baltimore, Boston, Los Angeles, Milwaukee, New York, and San Juan, with funding beginning in 1990. CSAT funded Philadelphia between the first and second rounds of award, and in 1993, CSAT funded the second generation of cities, which included Chicago, Cleveland, Dallas, Detroit, Miami, New Orleans, Newark, Portland, St. Louis, and San Francisco.

Program Description

Program requirements for the first and second generation of cities were similar, yet differed in important ways. CSAT required both generations to target service improvements for at least one of the following: adolescents, minorities, pregnant women, female addicts and their children, and residents of public housing. In 1993, CSAT refined the eligibility requirements to include persons who resided in the target jurisdiction, suffered from alcohol and drug problems, were unemployed or underemployed, and required publicly subsidized treatment. Both waves were mandated to propose models to (a) improve coordination among local drug abuse, health, mental health, education, law enforcement, judicial, correctional, and human service agencies; (b) establish or enhance central intake and referral facilities, (c) develop an automated patient tracking and referral system; and (d) implement measures to ensure the quality of services provided.

Discussions between the federal, state, and local project staffs who were involved with the first generation of Target Cities resulted in modifications to the requirements for the second wave of cities and shifts in the guidance that CSAT staff provided to program staff from those cities. During these discussions, staff identified several types of

problems specific to implementing a system change of the Target Cities Program's scope and magnitude. For example, program staff reported that in changing systems as large as those operating in most cities, the number of unforeseen variables and the vast differences in types of programs had to be considered simultaneously. The time required to effect change involving these entities was often much longer than the planning time allowed by CSAT.

In addition to a need for sufficient time to implement such a complex program, substantive differences existed in the ways in which treatment delivery systems operated prior to the Target Cities Program. Such vast differences limited the degree to which each city could implement a national model with standardized components (personal communication, Office of Treatment Improvement, Target Cities meeting, July 23, 1992). Modifications that worked in one area of the country would not necessarily be successful in another part of the country.

Another challenge in incorporating the lessons learned between the first and second wave of Target Cities was striking a balance between standardization and adequate flexibility to allow for local site differences. For example, the first-wave cities were required to establish or enhance central intake but were not provided with an operational definition of central intake. In the end, while both generations of cities were required to establish or enhance central intake and referral facilities, the goals differed between the two waves.

Therefore, one of the overriding differences between the first and second generations of Target Cities was the level of detail CSAT provided regarding the goals, interventions, and requirements. For the second generation of cities, CSAT was considerably more prescriptive, mandating specific activities and more clearly articulating the goals that produced important differences in the nature of the projects between generations. For example, among the first wave of Target Cities projects, central intake was *not* intended to "replace the existing outreach, case finding, and intake procedures of local treatment programs, but a local program could contract with the Central Intake Units (CIUs) to provide the program with assessment and intake services Employee assistance programs could also contract with the CIUs" (see the RFA in Appendix B in DHHS, 1990). In contrast, second-wave cities were clearly required to provide a comprehensive assessment to all participants. Given that this is often a time-consuming task requiring specialized staff capabilities not readily available in most publicly funded community-based treatment programs, it was assumed that centralizing the assessment function at one or more

sites, referred to as Service Delivery Units (SDUs), would obviate the need to invest resources to create these capabilities in each and every treatment provider location (DHHS, 1993, pp. 14–15).

In addition to more clearly defining the role for central intake, CSAT staff identified several goals for the project, and many of the activities deemed as "optional" in the first-wave cities were required activities for the second generation. Below is a list of the goals for the project, followed by a list of required activities for the second generation of Target Cities.

Program Goals

1. Increase access to treatment for those in need of treatment.
2. Increase the effectiveness of addiction treatment and recovery services in large metropolitan areas (i.e., to improve treatment outcomes for individuals with alcohol and drug problems and their families).
3. Foster coordination among addiction treatment and recovery programs and related health (e.g., TB/HIV/STDs), housing, welfare, job training, education, community redevelopment, social programs and institutions, and the legal system (e.g., police, courts, jails) as a means of involving alcohol- and drug-involved individuals in treatment and achieving improved treatment outcomes.
4. Develop methods by which metropolitan systems of care can continually improve treatment effectiveness.

Required Activities

CSAT did not require that all components of the proposed system be new. Specifically, the service system components already existing in an applicant metropolitan area were to be *combined* with the proposed system enhancements so that the system had the following capability (DHHS, 1993, p. 12):

1. To conduct an assessment of treatment staff training requirements, followed by the design and implementation of continuing professional education and other staff training programs and the evaluation of these activities.

2. To design and implement one or more central intake, assessment, and referral facilities wherein (a) a standardized, comprehensive intake assessment process is utilized to include a physical, screening for HIV, TB, STDs, and other infectious disease; alcohol and drug use history; psychosocial evaluation and, where warranted, a psychiatric evaluation; (b) standardized protocols are used for matching individuals with a continuum of appropriate treatment, recovery, and support services; (c) a case management system is implemented that is capable of tracking individuals across SDUs.
3. To establish a process whereby individual economic and social welfare needs are thoroughly assessed and addressed, including a determination of eligibility and subsequent registration for AFDC, food stamps, SSI, and so forth.
4. To establish linkages and formal referral processes whereby the ongoing preventive and primary health care needs can be met.
5. To case manage criminal justice participants through the various stages of treatment and legal case processing.
6. To develop a management information system capable of capturing current program characteristics, intake, assessment, referral and outcome data, financial data including charges and costs of treatment, and capacity utilization for every participant.
7. To incorporate an evaluation or management unit capable of utilizing the MIS to determine how successfully referrals were made, the length of stay, and which patients benefited from which programs.
8. To integrate a quality-assurance mechanism and provision of targeted technical and financial assistance designed to ensure that the quality of service delivery in participating SDUs is continually enhanced.

Evolution of the Multisite Evaluation

Local program evaluation was considered an integral part of the Target Cities demonstration project. The combined interest on the

part of both CSAT and local evaluators in each city led to a multisite evaluation. This effort began in February 1995 with a small group of evaluators meeting with CSAT staff to determine the feasibility of such an effort. At this point, data collection had begun at several sites, causing flexibility in instrumentation at some sites to be limited. Moreover, because cities could rely on a combination of already existing system components as well as new ones, variation in implementation across cities differed greatly. For example, Centralized Intake Units already existed in Detroit, whereas Chicago opened new ones and required participants to access treatment through them. In Cleveland, new CIUs were opened, but participants could still access treatment directly from a treatment program.

In spite of the variation across sites, evaluation designs, and instrumentation (described in more detail in chapter 2), the evaluators and CSAT staff determined that enough similarity existed across sites to develop several multisite databases that would capture important information about the demonstration project. During the next 5 years, the evaluators and CSAT staff met several times each year. During the initial stages of the collaboration, staff from the University of Akron completed a crosswalk to help identify the common data elements across sites and operated as a depository and distributor of the data on an ongoing basis (a more detailed description of the process is included in chapter 2).

Given the magnitude and complexity of the system changes resulting from the Target Cities Program, not every aspect of the change could be evaluated. Moreover, the variation and financial constraints across sites in many ways drove the focus of the local evaluations. For example, while case management became the focus in Detroit, Portland focused on increasing access to treatment for the criminal justice population.

The chapters in this book are based on data collected during implementation of the second generation of Target Cities. They are not intended to serve as a comprehensive compilation of all of the outcome data from the programs. Various topics are covered in other publications, including the implementation process at many sites, described by Guydish and Muck (1999a) in a special issue of the *Journal of Psychoactive Drugs*, the Management Information System (Hile, 1998), and other measures of treatment access and participant satisfaction (Scott, Muck, & Foss, 2000).

Many research questions remain that can be explored using the Target Cities data sets. It is important to note, as will be discussed in chapter 2, that the Target Cities data set is quite large and complex.

Attempts to use these data in isolation from a full explication of their construction and the understanding of the complexity and diversity of the programs will likely lead to specious conclusions.

Book Overview

The chapters in this book move between full multisite data comparisons, outcomes from subsets of sites, and single site outcomes. Due to the nature of initial development of the multisite data sets, relying on a combination of data sources provided a good method for addressing important issues related to the goals and objectives of the Target Cities Program. This also speaks to the complexity of the program. Within each Target Cities project, implementation was shaped by parallel forces including, but not limited to, the federal requirements, political agendas, and the ecological realities operating at each site. Although considerably more statistical power would have resulted from uniform implementation across sites, this requirement would have represented an inappropriate "cookie-cutter" approach to a highly complex project that now has the ability to inform many jurisdictions on a multiplicity of differing approaches to systems change.

It should not be surprising that much more detail can be provided from single sites concerning particular issues that were the focus of their local evaluations. However, each of these levels provides a perspective on this program that is important for understanding the implementation and outcomes and for gleaning information that will be useful for others planning modifications to large service delivery systems.

In chapter 2, following this present introductory chapter, Leahy, Stephens, Huff, and Kaye provide a description of the methodologies used across the sites and the procedures used to develop the multisite databases. In chapter 3, Claus and Dailey describe the CIU participant population as a whole as well as for each site. This chapter clearly illustrates the richness of the data and provides a snapshot of the more than 40,000 participants represented in the databases. As recommended by the 1990 Institute of Medicine report and called for by CSAT, the sample, and therefore the intervention, included a large number of pregnant women and women with children, as well as other subpopulations. It is important to note that this multisite sample is not representative of any participating site; it is, however, one of the largest samples of substance-abusing persons presenting for treatment assessment nationally.

In chapter 4, using cluster analysis for a random sample of the participants, Foss, Barron, and Arfken identify seven ways in which problems and patterns of service needs differed by site. The approach used in this chapter can be a critical component of a comprehensive needs assessment. The resulting need profiles allow for a clearer projection of the ways in which the type, environment, and modality of substance abuse services and linkages may be configured for a system most responsive to participants with multiple needs.

Issues pertaining to improved access to treatment, one of the major goals of the Target Cities Program, are reviewed in chapter 5. Claus, Barron, and Pascual present results based on data from one of the multisite databases as well as from single site evaluations. One of the issues raised during the planning phase of the project was whether or not adding the additional step of centralized intake would negatively impact participants' access to treatment. The authors concluded that despite the magnitude of the system change (including the added step of centralized intake, often located at a different location from treatment), the interventions increased access to treatment for underserved populations, decreased time to treatment entry, and maintained participant satisfaction with the intake process.

In chapter 6, Scott, Foss, and Sherman address a related issue by looking at a treatment satisfaction survey that was administered during a 6-month postintake follow-up interview. Levels of treatment satisfaction reported by participants who entered treatment prior to the opening of the Central Intake Unit were compared with levels of satisfaction reported by participants who accessed treatment through the CIU. The outcome of the comparison shows that centralizing intake did not negatively impact participants' perceptions of treatment services.

In chapter 7, Arfken, Klein, Agius, and diMenza explore the degree to which the critical interventions of matching, case management, and linkages were successfully implemented at the program sites. The achievements and downfalls of these implementations are analyzed utilizing a policy analysis framework adapted from Sabatier and Mazmanian (1979). This in-depth analysis provides a context in which to evaluate some of the results reported in other chapters and serves to inform administrators considering similar complex system changes.

The remaining chapters focus on participant outcomes using either multisite or single site databases. In chapter 8 Guydish et al. compare treatment outcomes for participants who accessed treatment before centralized intake with treatment outcomes for those who accessed it through centralized intake. Data from three cities—

Portland, San Francisco, and Chicago—contributed to these findings. The data compared in this chapter were collected during interviews conducted at intake and at either 6 months (Chicago) or 12 months (Portland and San Francisco) later. Based on ASI composite scores, participants in the CIU cohort did not demonstrate significantly better outcomes than participants who accessed treatment directly from treatment programs. It is also shown that outcomes differed by city.

Chapter 9 (Scott, Foss, & Sherman) includes a more detailed analysis of participant outcomes in Chicago. Centralized intake was established at two separate locations as part of the Target Cities project in Chicago. Outcomes for participants in the pre-CIU cohort were compared with participant outcomes in the CIU cohort. Participants in the CIU cohort demonstrated lower rates of drug use and better employment outcomes than participants in the pre-CIU cohort.

Chapter 10 (Finigan, Barron, & Carey) focuses on the development of a pretreatment In-Jail Intervention Program (IJIP) for substance-abusing criminal justice clients in the Portland Target Cities Project. The analysis focused on arrest and days of incarceration after participants completed the program. Results indicated a reduced number of subsequent rearrests. The final chapter (Guydish, Stephens, & Muck) provides a synthesis of the findings, explores lessons learned, and discusses policy implications that may be drawn from the experience gained during evolution of this program.

Prior to exploring the local and multisite outcomes in the Target Cities Program, it is critical to understand the breadth of the data collection efforts and the constraints in utilizing the data. The following chapter, "Methodological Issues in the Development of the Target Cities Multisite Databases," provides the detailed description necessary to this understanding and subsequent interpretation of the results of the several studies conducted within the program.