AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

QUITTING HARD HABITS: EFFORTS TO EXPAND AND IMPROVE ALTERNATIVES TO INCARCERATION FOR DRUG-INVOLVED OFFENDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

JULY 22, 2010

Serial No. 111–143

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.fdsys.gov
http://www.oversight.house.gov

U.S. GOVERNMENT PRINTING OFFICE

65–558 PDF WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

EDOLPHUS TOWNS, New York, *Chairman*

PAUL E. KANJORSKI, Pennsylvania
CAROLYN B. MALONEY, New York
ELIJAH E. CUMMINGS, Maryland
DENNIS J. KUCINICH, Ohio
JOHN F. TIERNEY, Massachusetts
WM. LACY CLAY, Missouri
DIANE E. WATSON, California
STEPHEN F. LYNCH, Massachusetts
JIM COOPER, Tennessee
GERALD E. CONNOLLY, Virginia
MIKE QUIGLEY, Illinois
MARCY KAPTUR, Ohio
ELEANOR HOLMES NORTON, District of Columbia
PATRICK J. KENNEDY, Rhode Island
DANNY K. DAVIS, Illinois
CHRIS VAN HOLLEN, Maryland
HENRY CUELLAR, Texas
PAUL W. HODES, New Hampshire
CHRISTOPHER S. MURPHY, Connecticut
PETER WELCH, Vermont
BILL FOSTER, Illinois
JACKIE SPEIER, California
STEVE DRIEHAUS, Ohio
JUDY CHU, California

DARRELL E. ISSA, California
DAN BURTON, Indiana
JOHN L. MICA, Florida
JOHN J. DUNCAN, JR., Tennessee
MICHAEL R. TURNER, Ohio
LYNN A. WESTMORELAND, Georgia
PATRICK T. McHENRY, North Carolina
BRIAN P. BILBRAY, California
JIM JORDAN, Ohio
JEFF FLAKE, Arizona
JEFF FORTENBERRY, Nebraska
JASON CHAFFETZ, Utah
AARON SCHOCK, Illinois
BLAINE LUETKEMEYER, Missouri
ANH "JOSEPH" CAO, Louisiana
BILL SHUSTER, Pennsylvania

RON STROMAN, *Staff Director*
MICHAEL MCCARTHY, *Deputy Staff Director*
CARLA HULTBERG, *Chief Clerk*
LARRY BRADY, *Minority Staff Director*

SUBCOMMITTEE ON DOMESTIC POLICY

DENNIS J. KUCINICH, Ohio, *Chairman*

ELIJAH E. CUMMINGS, Maryland
JOHN F. TIERNEY, Massachusetts
DIANE E. WATSON, California
JIM COOPER, Tennessee
PATRICK J. KENNEDY, Rhode Island
PETER WELCH, Vermont
BILL FOSTER, Illinois
MARCY KAPTUR, Ohio

JIM JORDAN, Ohio
DAN BURTON, Indiana
MICHAEL R. TURNER, Ohio
JEFF FORTENBERRY, Nebraska
AARON SCHOCK, Illinois

JARON R. BOURKE, *Staff Director*

CONTENTS

	Page
Hearing held on July 22, 2010	1
Statement of:	
Burch, James H., II, Acting Director, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice; and Benjamin B. Tucker, Deputy Director for State, Local and Tribal Affairs, Office of National Drug Control Policy	10
Burch, James H., II	10
Tucker, Benjamin B.	21
Hawken, Angela, Ph.D., associate professor of economics and policy analysis, School of Public Policy; John K. Roman, senior researcher, Justice Policy Center, Urban Institute; Douglas B. Marlowe, J.D., Ph.D., chief of science, law and policy, National Association of Drug Court Professionals; Daniel N. Abrahamson, director of legal affairs, Drug Policy Alliance; Melody M. Heaps, president emeritus, TASC, Inc.; and Harold A. Pollack, Helen Ross professor, University of Chicago School of Social Science Administration, faculty chair of the Center for Health Administration Studies	52
Abrahamson, Daniel N.	108
Hawken, Angela	52
Heaps, Melody M.	119
Marlowe, Douglas B.	88
Pollack, Harold A.	131
Roman, John K.	65
Letters, statements, etc., submitted for the record by:	
Abrahamson, Daniel N., director of legal affairs, Drug Policy Alliance, prepared statement of	110
Burch, James H., II, Acting Director, Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, prepared statement of	13
Hawken, Angela, Ph.D., associate professor of economics and policy analysis, School of Public Policy, prepared statement of	56
Heaps, Melody M., president emeritus, TASC, Inc., prepared statement of	122
Kucinich, Hon. Dennis J., a Representative in Congress from the State of Ohio, prepared statement of	4
Marlowe, Douglas B., J.D., Ph.D., chief of science, law and policy, National Association of Drug Court Professionals, prepared statement of	90
Pollack, Harold A., Helen Ross professor, University of Chicago School of Social Science Administration, faculty chair of the Center for Health Administration Studies, prepared statement of	134
Roman, John K., senior researcher, Justice Policy Center, Urban Institute, prepared statement of	67
Tucker, Benjamin B., Deputy Director for State, Local and Tribal Affairs, Office of National Drug Control Policy, prepared statement of	23

QUITTING HARD HABITS: EFFORTS TO EXPAND AND IMPROVE ALTERNATIVES TO INCARCERATION FOR DRUG-INVOLVED OFFENDERS

THURSDAY, JULY 22, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON DOMESTIC POLICY,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2154, Rayburn House Office Building, Hon. Dennis J. Kucinich (chairman of the subcommittee) presiding.

Present: Representatives Kucinich, Cummings, Watson, and Jordan.

Also present: Representative Davis.

Staff present: Jaron R. Bourke, staff director; Claire Coleman and Charles Honig, counsels; Charisma Williams, staff assistant; Marc Johnson, assistant clerk, full committee; Ron Stroman, staff director, full committee; and Adam Hodge, deputy press secretary, full committee.

Mr. KUCINICH. The meeting will come to order. This is the Subcommittee on Domestic Policy of the Committee on Oversight and Government Reform.

I want to thank all of you for your patience. The House had a series of votes which unfortunately came at the very beginning of the time that we wanted to commence this hearing. But your patience is much appreciated, and we will proceed now with the hearing.

I want to thank the ranking member, Mr. Jordan of Ohio, for his presence, as well as Ms. Watson from California.

Today's hearing is the fifth held by the Domestic Policy Subcommittee in this Congress on drug policy issues. This will be the first held by Congress to examine in comparative perspective different alternatives to incarceration that are being administered through the criminal justice system.

Without objection, the Chair and ranking minority member will have 5 minutes to make opening statements, followed by opening statements of 3 minutes by any other Member who seeks recognition.

And we are also joined by Mr. Davis of Illinois. Thank you for being here, sir.

Without objection, Members and witnesses may have 5 legislative days to submit a written statement or extraneous materials for the record.

The number of individuals incarcerated for drug offenses has increased every year since 1980, despite recent efforts, including drug courts and State-level initiatives like Proposition 36 in California that are explicitly designed to minimize jail and prison time for non-violent drug-related offenders and provide treatment for drug-related offenders. Overall, the correctional population has increased by nearly 2½ million, or 57 percent from 1990–2005. And the inflation-adjusted expenditures on corrections have more than doubled over the past 20 years.

Furthermore, the need for drug treatment among offenders still far outstrips supply. These trends have continued, even as overall illegal drug use, especially abuse of cocaine and heroin, has declined, and the drug-related offender population has aged, which should naturally lead to a decline in the need for incarceration given older offenders' decreased propensity for violence.

Why, and what can be done to reverse these trends? Certainly efforts at sentencing reform and improving how prisoners re-enter society, while not the focus of this hearing, are essential to break the cycle of drug abuse and crime and over-reliance on incarceration. Today's hearing has a slightly different focus and is the first congressional hearing to consider in a comparative perspective the various efforts within the criminal justice system itself to avoid incarceration and to provide drug treatment.

Drug treatment court is an important part of the picture. I have consistently supported the growth of drug and other problem-solving courts. And this subcommittee held a field hearing in Representative Cummings' district in Baltimore to witness how these courts are evolving to provide coordinated wrap-around services. Despite efforts to bring drug courts to scale, however, they only enroll about 100,000 clients per year out of an estimated 1½ million yearly arrestees with drug-related issues.

While this disparity is partly a result of limited funding, it is largely the result of eligibility restrictions that at times exclude offenders with histories of criminal violence, severe drug addiction problems and co-occurring disorders. While witnesses today will express optimism that drug courts can be expanded to include some of these offenders, and some of this expansion is justified by outcome studies and would be cost-effective.

It is clear that some aspects of their operation will have to change to reflect the different populations they serve. It is also clear that expanding the reach of drug courts is only part of the solution.

We will learn about a new approach demonstrated by Hawaii's HOPE program. HOPE attempts to coerce abstinence through frequent drug testing and the provision of swift and certain sanctions to probationers who continue to test positive. In contrast to drug courts, HOPE initially does not provide drug treatment and reserves a judicially imposed treatment plan for participants who fail to become abstinent in the face of graduated minor sanctions.

There has been some initial positive data on HOPE and there is a possibility it can help target drug treatment, which is costly, to

those who truly need it. Nevertheless, there are many important questions that need to be answered and the Hawaii experience needs to be attempted on the mainland before we can judge what role HOPE should play.

Finally, we look at the legacy of Proposition 36, which was passed by an initiative of California voters in 2000, and allows first or second time drug possession arrestees with no record of violent offenses to plead guilty to drug possession in return for diversion to a drug treatment program. While it has been criticized for lacking sufficient mechanisms to enforce the requirement that participants complete drug treatment, Proposition 36 has enrolled over 50,000 participants a year, amassing a wealth of relevant data to the proper design of diversionary programs.

The common feature of these programs and approaches that we focus on today is that they are alternatives to incarceration administered within the criminal justice system. We should be wary of thinking of one program, approach or set of approaches, no matter how well conceived, is the answer to over-incarceration. It is possible that programs can cross-hybridize or that different approaches are best understood as complementary and thus should be targeted to different drug-involved offending populations.

Congress must ensure that the Department of Justice and the Office of National Drug Control Policy, as policy experts, researchers and grantmakers, constantly measure the effectiveness of these programs, collect evidence about best practices, and, consistent with our notions of a just and safe society, help States make informed judgments.

Thank you very much. The Chair recognizes Mr. Jordan of Ohio.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Opening Statement
Dennis Kucinich, Chairman
Domestic Policy Subcommittee
Oversight and Government Reform Committee
"Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders"
July 22, 2010
2154 Rayburn HOB
2:00 P.M.

The number of individuals incarcerated for drug offenses has increased every year since 1980, despite recent efforts, including drug courts and state-level initiatives like Proposition 36 in California, that are explicitly designed to minimize jail and prison time for non-violent drug-related offenders and to provide treatment for drug-related offenders.

Overall, the correctional population has increased by nearly 2.5 million, or 57 percent, from 1990 to 2005; and inflation-adjusted expenditures on corrections have more than doubled over the past 20 years. Furthermore the need for drug treatment among offenders still far outstrips supply. These trends have continued even as overall illegal drug use, especially abuse of cocaine and heroin, has declined and the drug-related offender population has aged, which should naturally lead to a decline in the need for

incarceration given older offenders' decreased propensity for violence.

Why and what can be done to reverse these trends? Certainly, efforts at sentencing reform and improving how prisoners reenter society, while not the focus on this hearing, are essential to break the cycle of drug abuse and crime and overreliance on incarceration. Today's hearing has a slightly different focus and is the first Congressional hearing to consider in a comparative perspective the various efforts within the criminal system itself to avoid incarceration and to provide drug treatment.

Drug treatment courts are an important part of the picture. I have consistently supported the proliferation of drug and other problem-solving courts, and this Subcommittee held a field hearing in Representative Cummings' district in Baltimore to witness how these courts are evolving to provide coordinated wrap-around services. Despite efforts to bring drug courts to scale, however, they only enroll about 100,000 clients a year out of the estimated 1.5 million yearly arrestees with drug-related issues. While this disparity is partly resulting in limited funding, it is largely the result eligibility restrictions that at times exclude offenders with histories of criminal violence, severe drug

addiction problems, and co-occurring disorders. While witnesses today will express optimism that drug courts can be expanded to include some of these offenders and such expansion is justified by outcome studies and would be cost-effective, it is clear that some aspects of their operation will have to change to reflect the different populations that they serve. It is also clear that expanding the reach of drug courts is only part of the solution.

We will also learn about a new approach demonstrated by Hawaii's HOPE program. HOPE attempts to coerce abstinence through frequent drug testing and the provision of swift and certain sanctions to probationers who continue to test positive. In contrast to drug courts, HOPE initially does not provide drug treatment and reserves a judicially-imposed treatment plan for participants who fail to become abstinent in the face of graduated minor sanctions. There has been some initial positive data on HOPE and there is a possibility it can help target drug treatment, which is costly, to those who truly need it. Nevertheless, there are many important questions that need to be answered and the Hawaii experience needs to be attempted on the mainland before we can judge what role HOPE should play.

Finally, we look at the legacy of Proposition 36, which was passed by an initiative by California voters in 2000 and allows first- or second-time drug possession arrestees with no record of violent offenses to plead guilty to drug possession in return for diversion to a drug treatment program. While it has been criticized for lacking sufficient mechanisms to enforce the requirement that participants complete drug treatment, Prop 36 has enrolled over 50,000 participants a year, amassing a wealth of data relevant to the proper design of diversionary programs.

The common feature of the programs and approaches that we focus on today is that they are alternatives to incarceration administered within the criminal justice system. We should be wary of thinking of one program, approach, or set of approaches, no matter how well conceived, is the answer to overincarceration. It is possible that programs can cross-hybridize or that different approaches are best understood as complementary and should thus be targeted to different drug-involved offending populations. Congress must ensure that DOJ and ONDCP, as policy experts, researchers, and grant-makers, constantly measure the effectiveness of these programs, collect evidence about best practices, and, consistent with our notions of a just and safe society, help states make informed judgments.

Mr. JORDAN. Thank you, Mr. Chairman. I will be brief.

I want to thank you for holding this hearing to create continuing disincentives for drug-involved offenders. And incarceration has been a primary and an effective solution. Today, 1 out of 100 Americans has spent time behind bars, sometimes disproportionately repeat offenders.

Solutions to preventing incarceration are critical. Treatment in the type of local community-based care given to those with substance abuse and mental health disorders are necessary to fostering permanent, positive behavior changes. Treatment, along with training and skill development and stopping the flow of drugs across the border are the only ways to ensure we no longer have drug abusers.

We must bear in mind that solutions which work for one person do not always work for another. Today I look forward to learning about the various tried-and-true solutions from our witnesses. It is my opinion, I just want to emphasize this, that legalizing drugs is certainly not the solution to preventing incarceration. It is not the solution to dealing with our drug problems. The harm to communities and families as a result of drug use has nothing to do with our current laws. We must work to prevent, control and mitigate addiction as we continue to fight this overall destructive behavior.

With that, I will yield back, and I look forward to our witnesses.

Mr. KUCINICH. I thank the gentleman.

The Chair recognizes Ms. Watson of California.

Ms. WATSON. Thank you so much, Mr. Chairman. I want to thank you for holding this exceedingly important hearing on the front-end alternatives to incarceration for drug-involved offenders and abusers of illegal drugs.

This hearing occurs at an opportune moment. Each year, our prison population grows, creating a heavy human cost for our communities and an increasingly large burden on the already strained budgets of our States. In California at this time, we have a proposition on the ballot that attempts to legalize marijuana, which I am very opposed to. But they are looking for a way to receive more revenues and they think they can do it this way. There is nothing to resolve the problem of the addictive use.

So as we analyze the Nation's approach to reducing the availability and abuse of drugs, it is important to emphasize both the individual and group costs of addiction. Domestically, the disease of addiction has devastating consequences for individuals, families, communities and our judicial and health care systems. While on an international scale, as stated by Secretary of State Clinton while in Mexico, our insatiable demand for illegal drugs fuels the drug trade.

It is imperative that we define and demolish the barriers to treatment for the millions of Americans struggling to regain themselves from the depths of addiction. By providing treatment and incentives to get clean, we can begin to reduce the rates of incarceration and recidivism for those who are abusing or addicted to drugs.

In 2000, voters from my State of California recognized the need for alternatives to incarceration by some non-violent drug offenders and passed Proposition 36 by popular referendum. While there are

clear limitations to this program, I am eager to hear from today's witnesses about Proposition 36 and other non-conventional methods of reducing incarceration levels while making our communities stronger and safer.

I would like to thank all the witnesses today for their testimony, and you, Mr. Chairman, for your leadership and your dedication to this issue. I yield back the remainder of my time.

Mr. KUCINICH. I thank the gentlelady. And the Chair recognizes Mr. Davis of Illinois.

Mr. DAVIS. Thank you very much, Mr. Chairman. Let me first of all thank you for giving me the opportunity to sit in on this hearing, although I am not a member of this subcommittee. One of the big tasks that I had to make in the last reorganization was to not be on this committee. [Laughter.]

And I am always delighted to get a chance to come by.

Mr. KUCINICH. I would like to say, if I may, as chairman, that I ask unanimous consent to permit Mr. Davis, who is not a member of this subcommittee, to participate in this subcommittee. Without objection you may proceed.

Mr. DAVIS. Thank you very much, again, Mr. Chairman. I want to thank you for tackling the big issues, the heavy ones, the tough ones. You have a long history of doing that, and so I wouldn't expect you to do anything else.

I want to thank all of the witnesses for coming. Because given the fact that our country, this country has the largest number of individuals incarcerated of any nation on the face of the earth in proportion to population, as well as in actual numbers. So trying to find alternatives to incarceration, I think, is just one of the major things that we ought to be doing.

I appreciate all of the witnesses who are here, especially one, Melody Heaps, with whom I have worked for any number of years and consider to be one of the foremost authorities on alternatives to incarceration in the Nation in relationship to how you handle the drug treatment problem, the issues related to drugs, and especially individuals who are also incarcerated, have been incarcerated, might become incarcerated, and also make use of drugs as a part of the lifestyle.

So I thank you, Mr. Chairman, thank all of the witnesses and yield back the balance of my time.

Mr. KUCINICH. Thank you very much, Mr. Davis.

If there are no other opening statements, the subcommittee will now receive testimony from the witnesses before us today. I want to introduce our first panel.

Mr. James H. Burch, II, is Acting Director of the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, where he has served for nearly 15 years. Prior to his appointment as Acting Director, Mr. Burch served as the Deputy Director of Policy at BJA, overseeing an office and efforts designed to provide leadership in criminal justice policy, training and technical assistance, and to further the administration of justice.

Mr. Burch began his career in public service at the local level, working for several years on case and records management and automation for the Circuit Court in Prince George's County, Maryland as a civilian within a local law enforcement agency.

We also have with us Mr. Benjamin B. Tucker. Mr. Tucker is the newly confirmed Deputy Director for State, Local and Tribal Affairs for the Office of National Drug Control Policy. Beginning his career as a beat cop in New York City's police department, Mr. Tucker has 40 years of experience in the fields of law enforcement and criminal justice. He is a recognized expert in community policing.

An attorney prior to joining the ONDCP, Mr. Tucker served as a professor of criminal justice at Pace University, Director of Field Operations and Senior Research Associate at the National Center on Addiction and Substance Abuse at Columbia University, in the Department of Justice and in various positions in the New York City Government.

Director Burch and Deputy Director Tucker, this subcommittee is very grateful for your appearance today and also grateful for your service to the people and to this country.

It is the policy of the Committee on Oversight and Government Reform, gentlemen, to swear in all witnesses before they testify. I would ask that you stand and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Let the record reflect that both of the witnesses have answered in the affirmative.

I have to say that in the 14 years I have been in Congress, I don't think I have ever had anyone say, I don't. [Laughter.]

I would ask that each witness give an oral summary of your testimony. Keep this summary to about 5 minutes. Your complete written statement will be in the hearing record.

Mr. Burch, you are the first witness on this panel. Thank you for being here. I ask that you proceed.

STATEMENTS OF JAMES H. BURCH II, ACTING DIRECTOR, BUREAU OF JUSTICE ASSISTANCE, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE; AND BENJAMIN B. TUCKER, DEPUTY DIRECTOR FOR STATE, LOCAL AND TRIBAL AFFAIRS, OFFICE OF NATIONAL DRUG CONTROL POLICY

STATEMENT OF JAMES H. BURCH II

Mr. BURCH. Chairman Kucinich, Ranking Member Jordan, Congresswoman Watson, Congressman Davis, I want to thank you all for the opportunity to be here today.

Today I hope to discuss alternatives to incarceration in the State, local and tribal criminal justice systems, and the Department's commitment to supporting smarter approaches to preventing and reducing crime. It is well known that crowded jails and prisons, as you have talked about here today, and high recidivism, continue to seriously strain State and county budgets.

In response, the Office of Justice Programs at the Department of Justice and its Bureau of Justice Assistance has shifted its focus to more strategic, more effective and sustainable approaches to addressing crime that recognizes the critical role of evidence-based strategies and sentencing alternatives.

We believe that we have a responsibility to be not only tough on crime, but more importantly, to be smart on crime. This means supporting programs that are backed by evidence of effectiveness, not simply ideology. The Bureau of Justice Assistance believes that

pretrial justice strategies, for example, can play a major role in reducing recidivism and corrections costs.

A Bureau of Justice statistics survey found that more than 60 percent of people confined in jail on any given day were those awaiting trial, frequently for a non-violent offense, and many of whom were later sentenced to something other than incarceration. This fact suggests that an alternative may have been appropriate at an earlier stage in the justice process.

Further, by implementing pretrial justice strategies, including the use of research based risk assessment instruments, communities may be able to more efficiently and effectively use community supervision alternatives and reduce spending on corrections.

To gain the foothold needed to be successful with community supervision and re-entry, we must capitalize on the opportunities presented at the front end of the system. For instance, many adults and juveniles have been successfully diverted from further offending by programs that use the leverage and the monitoring power of the court, together with treatment and broad community collaboration. One example of this problem-solving approach are drug courts, which have been shown to be effective in addressing substance abuse problems, as well as reducing recidivism.

Through a National Institute of Justice multi-site drug court evaluation, researchers are identifying what specific drug court practices are most effective and under what conditions, both of which will help us to further refine the drug court grant programs that we administer and ensure that we are supporting evidence-based strategies. I understand that Dr. Roman will discuss some preliminary results of this study later today.

BJA is also working to strengthen probation and parole strategies. For example, Hawaii's HOPE program, which I go into greater detail about in my written statement, is one such strategy. The President's fiscal year 2011 budget submission to Congress proposes a smart probation program that will provide $10 million in funding for State, local and tribal jurisdictions to replicate strategies such as Hawaii HOPE.

Another example of a strategy designed to enhance safety and reduce corrections spending is the Justice Reinvestment Initiative. Through this initiative, BJA is assisting State, local and tribal communities in conducting a thorough review of the local drivers of corrections costs and the identification of policy alternatives to reduce costs and increase effectiveness. To date, this initiative has shown significant results across the country. In one example, from the State of Vermont, our efforts are expected to yield an estimated $54 million in net savings through fiscal year 2018, with a portion of this savings to be reinvested in improved assessments, expanded residential treatment and vocational training.

In each of these programs, we see examples of how evidence plays a role in shaping policy and practice. The Attorney General has made it a priority to develop and enhance evidence-based practice that buildupon current approaches while also encouraging innovation. Hand in hand with supporting research is the responsibility for translating it for use and integrating evidence into the work of justice professionals. This initiative is discussed as well in greater detail in my written testimony.

Recidivism is a complicated problem and there is a lot more for us to learn in this area. Confronting recidivism in a more balanced way means recognizing the role of prevention, pre-trial services, treatment and sentencing alternatives. Each of the strategies I discuss today are valuable tools that represent opportunities to maximize the effectiveness of State, local and tribal justice systems, and to make our communities safer.

Mr. Chairman, this concludes my statement. I welcome any questions that you may have.

[The prepared statement of Mr. Burch follows:]

Department of Justice

STATEMENT OF

JAMES BURCH
ACTING DIRECTOR
BUREAU OF JUSTICE ASSISTANCE
OFFICE OF JUSTICE PROGRAMS

BEFORE THE

SUBCOMMITTEE ON DOMESTIC POLICY
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"QUITTING HARD HABITS: EFFORTS TO EXPAND AND IMPROVE ALTERNATIVES TO INCARCERATION FOR DRUG-INVOLVED OFFENDERS"

PRESENTED

JULY 22, 2010

Chairman Kucinich, Ranking Member Jordan, and distinguished Members of the Subcommittee, thank you for the opportunity to be here today. We appreciate this Subcommittee's interest in this important and timely topic.

My name is Jim Burch and I am the Acting Director of the Bureau of Justice Assistance (BJA) in the Office of Justice Programs (OJP), U.S. Department of Justice (DOJ). BJA's mission is to provide leadership and services in grant administration and criminal justice policy development to support state, local, and tribal justice strategies to achieve safer communities. I have served in OJP for more than 16 years and prior to my appointment as the Acting Director, I served as the Deputy Director for National Justice Policy at BJA. The Policy Office focuses on state and local justice issues, such as law enforcement, information sharing, the courts, community and institutional corrections, substance abuse, tribal justice, and crime prevention. The Policy Office also acts as a liaison to national organizations that partner with BJA to guide local justice policy and help disseminate information on best and promising practices from around the country. Today, I'll be discussing alternatives to incarceration and the Department of Justice's commitment to a more strategic, effective, and efficient approach to preventing and reducing crime.

It will come as no surprise to this Subcommittee that crowded jails and prisons and high recidivism rates across the country are wreaking havoc on state and municipal budgets. According to OJP's Bureau of Justice Statistics (BJS), there are currently more than 1.5 million individuals serving time in federal and state prisons and another 786,000 incarcerated in local jails. About 725,000 individuals are released from prison and millions of people cycle through local jails every year. According to the Council of State Governments (CSG) Justice Center, in the past 20 years state spending on corrections has grown at a faster rate than nearly any other state budget item. In Michigan, for example, corrections spending accounts for almost a quarter of state general fund expenditures, and one in three state employees works for the state's department of corrections. Other states are facing similar dilemmas.

The U.S. Department of Justice is responding to these challenges in a number of ways. First, we need to focus on a more strategic, effective, and sustainable approach to addressing crime that recognizes the critical role of evidence-based prevention strategies as well as pretrial justice strategies and sentencing alternatives. Validated risk assessments in justice decision-making and treatment will lead to better outcomes for communities without relying exclusively on costly and unsustainable options for those who may not require it. Second, as a general matter, we believe we have a responsibility to be not only tough on crime, but also smart on crime. This means supporting programs that are backed by evidence of effectiveness, not just ideology.

Pretrial Justice Strategies

Shrinking budgets and growing jail and prison populations have created the "perfect storm" for state and local policy reform - an opportunity for policymakers to enhance justice systems in a more efficient and innovative way while encouraging collaboration and improving public safety. BJA believes pretrial justice strategies can play a major role in this effort, not only in reducing recidivism and correctional facility crowding, but also in reducing corrections costs.

According to the National Association of Counties (NACo), more than half of defendants in pretrial detention are later sentenced without incarceration, which suggests that many in pretrial detention could await trial in alternative settings. A Bureau of Justice Statistics Inmate Survey conducted in 2008 found that more than 60 percent of persons who were confined in jail on any given day were those awaiting trial, frequently for a non-violent offense. By implementing pretrial justice strategies that facilitate risk assessments of offenders and then match those offenders with appropriate services, state and local communities may be able to efficiently and effectively utilize community supervision alternatives to protect public safety, reserving the use of jail and prison space for the most serious of criminal offenders.

In partnership with many national organizations, BJA is providing training and technical support for many front-end decision-making practices and closely examining the role that pretrial services, prosecution, adjudication, and sentencing can play in making the criminal justice process more effective. For example, the President's FY 2011 budget includes $5 million for an Ensuring Fairness and Justice in the Criminal Justice System initiative, which includes funding for these very front-end decision-making points. Specifically, this initiative, if funded, will support efforts to provide training and technical assistance and to identify best practices in pretrial justice, as well as support for strategic and effective decision-making by defenders, prosecutors, and judges, and will also provide support for more general court improvement efforts.

We must capitalize on the opportunities presented at the front-end of the system to gain the foothold needed to be successful with reentry and other post-conviction efforts. Effective reentry planning must begin when an offender first comes into contact with the criminal justice system. The steps that follow -- such as decisions to incarcerate versus decisions to find alternatives to incarceration that include a wide variety of medical treatment and accountability -- are vital. Validated risk assessment during pretrial decision-making and sentencing are necessary to permit the safe release of certain defendants—without jeopardizing community safety or the integrity of the legal process.

Smart Policing

Encounters with law enforcement often play a critical role in whether or not people with mental illness, or co-occurring disorders such as mental illness and substance abuse, are identified for and directed to appropriate treatment for their underlying illness or are simply incarcerated and continue to cycle in and out of jails and prisons. Many law enforcement officials, frustrated by the lack of effective options for responding to these issues, are partnering with local mental health advocates and service providers to make it easier to connect people to treatment on the front-end of the criminal justice process. BJA partnered with the Council of State Governments Justice Center and NACo on a number of publications that address issues such as law enforcement responses to individuals with mental illnesses, mental health courts, effective reentry practices for people with mental health issues, and state and county collaboration. The International Association of Chiefs of Police also partnered with BJA recently on this very issue, holding a summit for law enforcement and mental health professionals that resulted in a report of recommendations to support law enforcement who respond to calls involving people with mental illness.

Research shows that effective policing also requires a tightly focused, collaborative approach that is measurable; based on sound, detailed analysis; and includes policies and procedures that promote and support accountability. In support of these goals, BJA partnered with the CNA Corporation, which has extensive experience in law enforcement operations and evaluation, to provide training and assist with the development and implementation of Smart Policing strategies in 10 sites. These 10 sites, selected under a national competitive solicitation in FY 2009, are law enforcement agencies that represent a diverse sampling of agency size, type of crime challenge, and law enforcement approach, such as place- and offender-based policing, problem oriented policing, intelligence-led policing, and victim-based policing. Each site is required to work with a research partner and will develop and evaluate smarter, data-driven law enforcement practices to reduce and prevent crime.

Every local justice system component - law enforcement, prosecutors, defenders, and judges - plays a key role in front-end decision-making and they all have a stake in the outcome of the criminal case process as professionals and members of their respective communities.

Sentencing Alternatives

Problem-Solving Courts

Many of today's court cases involve individuals with medical, psychological, and social problems such as substance abuse, homelessness, or lack of access to mental health treatment, which drive criminal behavior. However, many adults and juveniles have been steered away from further offending by programs that use the coercive and monitoring power of the court. Traditional court practices have not always been shown to be particularly effective in addressing the underlying social and psychological issues that propel individuals into involvement with the justice system. Problem-solving forums such as drug, mental health, and reentry courts that rely on collaboration with social service, public health, and other criminal justice agencies, have been shown to be effective in addressing these underlying problems and in reducing recidivism.

One such program, Back on Track, in San Francisco is a problem-solving court aimed at reducing recidivism among low-level drug-trafficking defendants. Back on Track combines strict accountability with real opportunities for self-improvement. Participants must find employment, enroll in school full time, and comply with all the terms of an individualized Personal Responsibility Plan (PRP). Over a two-year period, Back on Track has reduced recidivism among its graduates to less than 10 percent. In comparison, 53 percent of California's drug offenders return to prison or jail within two years of release. The program has been adopted by the National District Attorneys Association as a model program and is being replicated in other states.

During FY 2010, BJA is directing $57 million in funding for problem-solving courts through the Drug Court Discretionary Grant Program and the Justice and Mental Health Collaboration Program. The FY 2011 Budget Request, also $57 million, combines these two successful programs into a single Problem-Solving Courts Initiative, allowing state, local, and tribal jurisdictions increased flexibility in funding strategies that address unique local needs and that can expand collaboration among drug courts, mental health, and substance abuse providers.

Research funded by OJP's National Institute of Justice (NIJ) and others verifies that problem-solving courts significantly improve mental health and substance abuse treatment outcomes, substantially reduce crime, and produce greater cost benefits. Research is clear that drug courts can reduce recidivism and future drug use. One study that looked at the impact of mature drug courts over ten years showed that compared to traditional criminal justice system processing, treatment, and other investment, costs averaged $1,392 lower per drug court participant. Reduced recidivism and other long-term program outcomes resulted in an average public savings of $6,744 per participant. These savings rose to $12,218 if victimization costs are included (http://www.ncjrs.gov/pdffiles1/nij/grants/219225.pdf).

Research findings show that drug courts can reduce recidivism and promote other positive cost-saving outcomes. Various factors affect a drug court program's success, such as proper assessment and treatment, the role assumed by the judge and the nature of offender interactions with the judge, and other variable influences such as drug use trends, staff turnover and resource allocation. These and other issues, such as treatment service delivery and judicial interaction, are addressed in the NIJ special report, Drug Courts: The Second Decade (http://www.ncjrs.gov/pdffiles1/nij/211081.pdf). In addition, through a Multisite Adult Drug Court Evaluation program, NIJ researchers are now examining underlying processes to identify what practices are effective, for whom, and under what conditions. Preliminary findings can be found on the NIJ website: http://www.ojp.usdoj.gov/nij/topics/courts/drug-courts/madce.htm.

Smart Probation

We know that spending more on prisons does not equate to more public safety because, in spite of mounting expenditures, recidivism rates remain high. Research by BJS indicates that half of all individuals released from state prison are sent back within three years. Most of the people released from prison, and many people released from jail, are placed under some form of community supervision. In 2008, the Pew Center on the States reported that 7.3 million people, or 1 in every 31 adults, were under correctional supervision.

Over the years, we have given remarkably little attention, and few resources, to probation and parole. Today, BJA is working with state probation and parole agencies to help them focus their efforts and their criminal justice dollars on targeting high-risk offenders and reducing prison populations in a more effective and efficient way to better serve public safety. The President's Fiscal Year 2011 Budget request includes $10 million for a program called, "Smart Probation: Reducing Prison Populations, Saving Money, and Creating Safer Communities." Managing our corrections population is a critical challenge facing our justice system. Some states and communities have found effective and sustainable ways of managing their probationers and parolees, such as Hawaii's Opportunity Probation with Enforcement (HOPE) Program, which I will discuss in greater detail later, or Maricopa County's strategy in Arizona of creating financial incentives for the Probation Department when recidivism is reduced. The Smart Probation program would build upon this progress and help other jurisdictions improve supervision strategies through data collection and analysis, better interagency coordination, replication of evidence-based efforts, and training and technical assistance.

Hawaii's Opportunity Probation with Enforcement (HOPE) Program

Too often convicted felons routinely fail to show up for appointments, decline to take mandatory drug tests, or fail mandatory drug tests without immediate accountability. A judge in

Hawaii decided to take a new approach involving law enforcement, local jail officials, probation officers, drug treatment professionals, prosecutors, and defense counsel to collaborate on an initiative known as Hawaii's HOPE Program. The HOPE Program is a probation initiative that emphasizes the delivery of "swift and certain" punishment when an offender violates conditions of probation. Those who violate the conditions of probation are arrested immediately, appear in court within hours, and have the terms of their supervision modified to include a short stay in jail. The court also assists in providing access to social services for probationers who need drug abuse treatment, mental health treatment, or other social services. Results from a recent NIJ-funded evaluation of the HOPE Project are encouraging. Compared to probationers in a control group, after one year HOPE probationers were 55 percent less likely to be arrested for a new crime, 72 percent less likely to use drugs, 61 percent less likely to skip appointments with their supervisory officer, and 53 percent less likely to have their probation revoked. As a result, HOPE probationers served or were sentenced to 48 percent fewer days, on average, than the control group. These are dramatic findings -- and ones we hope to see replicated in other jurisdictions.

Justice Reinvestment

The economic challenges that many state, local, and tribal jurisdictions face today require us to reemphasize the critical importance of cost effectiveness within the overall determination of what works and how well it works. Families, neighborhoods, communities, and states can no longer afford to rely on incarceration as a universal option for all offenders. In partnership with the CSG's Justice Center, and other national organizations, BJA launched its Justice Reinvestment initiative in 2006. This approach is a highly strategic effort that includes extensive collection and analyses of corrections, crime, and resource data. By using this approach, state, local, and tribal policymakers are better able to assess their criminal justice systems and implement policy options that control spending on corrections and ensure that those cost savings are reinvested in benefits and services such as substance abuse prevention and treatment programs to prevent crime and increase public safety.

Justice Reinvestment has shown significant results in communities throughout the country. In Kansas, for example, the prison population was expected to increase 22 percent by 2016 at a cost of approximately $500 million in additional construction and operating costs. Analysis by experts from CSG's Justice Center showed that violations of parole and probation in Kansas were a significant factor in individuals returning to prison. In response, the state enacted new policies and redirected $7.9 million to strengthen probation and parole operations and expand treatment programs. As a result, the state prison population decreased by four percent and recidivism rates declined by more than 20 percent.

As a result of similar successes across the nation, additional states are beginning to implement Justice Reinvestment strategies. Vermont, one of the least populous states in the country, was among the states with the fastest growing prison populations in the nation. To keep pace with the growth in the prison population, state spending on corrections increased from four percent of state general funds in 1990 to 10 percent of state general funds in 2008. Over several years, Vermont policymakers designed numerous innovative strategies, including intensive community-based supervision and substance abuse treatment, to reduce this rate of recidivism, but no data-driven mechanism existed to guide decisions about who received particular

resources. Consequently, policymakers could not track the impact of these programs on recidivism rates and public safety.

With bipartisan support, policymakers in Vermont decided to employ a Justice Reinvestment strategy, using rigorous data analyses. In turn, the state enacted new policies and programs that, if implemented effectively, will help reduce the state's need to contract for out-of-state capacity to house the prison population and avert the need to construct new prisons, yielding an estimated $54 million in net savings between FY 2009 and FY 2018. State officials developed a plan to reinvest $3.9 million of the projected savings over the next two years to support assessment tools to identify people with substance abuse needs prior to release, to expand in-prison substance abuse treatment and vocational training, and to increase funding for a transitional housing program to include housing assistance and life skills training.

In fiscal year 2010, BJA issued a competitive solicitation to expand our Justice Reinvestment initiative by reaching additional states, counties, and tribal governments and by expanding the number of national organizations participating as technical assistance providers. Through this solicitation, BJA will also make available seed funding for states, counties, and tribes to implement policy options identified to reduce costs and improve outcomes. Additionally, BJA has worked closely with the Pew Center on the States to develop a process for more closely aligning our Justice Reinvestment efforts to ensure that states participating in the initiative with BJA and /or Pew will be eligible for further support through both organizations.

Evidence-Based Crime Prevention

Evidence Integration Initiative

In problem-solving courts, justice reinvestment strategies, and unique probation programs, we see examples of how evidence can play a role in shaping policy and practice. The Attorney General has made it a priority to support, develop, and enhance evidence-based practices that build upon current models and encourage innovative approaches and strategies nationwide. This means that supporting research is a vital part of OJP's mission. Hand in hand with supporting research is the responsibility for translating it for use and integrating evidence into the day-to-day work of justice professionals.

To meet these goals, OJP's Assistant Attorney General, Laurie Robinson in 2009 launched a new Evidence Integration Initiative, or E2I, for short. This is an agency-wide effort, and it has three objectives: 1) improve the quantity and quality of evidence that we generate through research, evaluations, and statistics; 2) better integrate evidence into program and policy decisions; and 3) improve the translation of evidence into practice.

Above all else, E2I will help us expand programs that work, such as the ones I have mentioned today. By providing clear evidence and easy-to-use resources, E2I will help us nourish successful programs and reform those that don't work using proven models. With E2I, we are not starting over; we are capitalizing on our existing successes and creating an environment where they can be easily replicated. E2I incorporates careful study, thorough analysis, and practical tools and will help us do more to provide viable alternatives to incarceration.

Our objective with E2I is to help criminal justice policymakers and practitioners better understand what has been shown to work, and we are already taking some specific steps. For example, we are working to establish common expectations and definitions for credible evidence across programs. We are forming Evidence Integration Teams to synthesize evidence on specific justice topics, such as children exposed to violence and gangs, and to develop principles for practice that can be communicated to the field. In addition, we are focusing on how to get information out to practitioners and policymakers in a format that is accessible and useful.

The President has requested funding for two critical elements of E2I in his Fiscal Year (FY) 2011 Budget Request. One is a Crime Solutions Resource Center and the other element is a diagnostic center, or "help desk," that will provide direct support to jurisdictions as they apply these approaches. These projects are rooted in our commitment to supporting, developing, and enhancing evidence-based practices, building upon current models, and encouraging innovative strategies in the field.

Conclusion

Recidivism is a complicated problem, and we need to acknowledge that there is a lot more to learn in this area. At OJP, we are committed to investing in research to ensure we spend public dollars wisely. Confronting challenges associated with recidivism in a more balanced way means recognizing the role of prevention, pretrial services, sentencing alternatives, and treatment. Each of the national projects I discussed today is a valuable tool that represents an opportunity to maximize the effectiveness of state and local systems and make our communities safer.

This concludes my statement, Mr. Chairman. Thank you for the opportunity to testify today. I welcome the opportunity to answer any questions you or other Members of the Subcommittee may have.

Mr. KUCINICH. Thank you, Mr. Burch.

The Chair recognizes Mr. Tucker. You may proceed.

STATEMENT OF BENJAMIN B. TUCKER

Mr. TUCKER. Chairman Kucinich, Ranking Member Jordan, distinguished members of the subcommittee, thank you for the opportunity to appear before you today to discuss alternatives to incarceration.

Having walked a beat as a New York City police officer and working in criminal justice for more than 35 years, I understand that in order to break the cycle of drug use, crime and incarceration, it is important to identify and foster effective alternatives to incarceration.

The Obama administration's 2010 National Drug Control Strategy also reflects this premise as it places an unprecedented focus on the importance of such innovations in the criminal justice system and recognizes that prevention, treatment, recovery, support and enforcement are all essential components of an effective approach to addressing drug use and its consequences.

Due to the desire to reduce recidivism, the high costs of incarceration, budgetary constraints and the recognition that incarceration is not always the most effective solution for those with substance use disorders, all levels of government are exploring new approaches and expanding proven efforts.

When discussing alternatives to incarceration, it is important to recognize specific front-end alternatives, such as prevention, early intervention and treatment, all of which keep individuals from ever entering the criminal justice system. The President's 2011 budget request reflects the increased emphasis on prevention by requesting approximately $1.7 billion to support prevention programs.

Another important component to provide front-end alternative to incarceration is facilitating effective early intervention and treatment for individuals with drug use problems. Addiction is a chronic, complex disease, both psychological and biological in nature, and should be managed in the same way as other chronic conditions. However, because substance abuse treatment is not fully integrated into the health care system, too many substance abuse problems go unrecognized. This decreases the chances abusers will seek treatment and increases the possibilities for criminal activity. Therefore, involvement with the criminal justice system may be the first time an individual has the motivation and the opportunity to address his or her substance use problem.

For these reasons, it is important that the criminal justice system has the capacity to effectively treat drug use. It is why the fiscal year 2011 budget requests $3.9 billion to support treatment programs. The reality is that even the best prevention, intervention and treatment efforts may not help every person. For some, drug use results in criminal and delinquent behavior, disrupting family, school, neighborhood and community life in fundamental and long-lasting ways.

The majority of drug-involved offenders are in State correctional systems, and many of the low risk offenders are sentenced to probation and supervised through a variety of programs. The type of programs selected for the offender will depend on his or her par-

ticular set of circumstances. The range of programs includes specialty courts, community supervision, residential treatment programs, testing and sanctions programs, drug market interventions and programs that use monitoring devices.

ONDCP is shepherding policies that will transform systems and force partnerships, bringing together a wide range of services that will help people in recovery, build and maintain a substance-free lifestyle, while also reducing recidivism. Typical recovery support services include safe and sober housing, medical and dental care, mental health treatment, employment training and placement, family counseling, child care and transportation. The Federal Government's role in these efforts is to provide guidance by highlighting model programs, ensuring Federal assistance promotes effective long-term approaches, and requiring evaluations to determine program effectiveness.

As reflected in the National Drug Control Strategy, combining effective and fair enforcement with robust prevention and treatment efforts will enable us to be successful in addressing drug use and its consequences.

I look forward to working with the subcommittee to address these challenging and important issues. Once again, than you very much for the opportunity to testify and for the support of the subcommittee on these vital matters.

[The prepared statement of Mr. Tucker follows:]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

"Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders."

House Committee on Oversight and Government Reform
Subcommittee on Domestic Policy

Thursday, July 22, 2010
2:00 p.m.
2154 Rayburn House Office Building

Written Statement
of
Ben B. Tucker
Deputy Director for State, Local, and Tribal Affairs

House Oversight and Government Reform Committee
Domestic Policy Subcommittee
July 22, 2010

Written Statement of Ben B. Tucker
Deputy Director, Office of State, Local, and Tribal Affairs
Office of National Drug Control Policy

Chairman Kucinich, Ranking Member Jordan, distinguished members of the Subcommittee, thank you for providing me with the opportunity to appear before you today to discuss alternatives to incarceration. As the newly confirmed Deputy Director of the Office of State, Local, and Tribal Affairs in the Office of National Drug Control Policy, it is an honor to appear before you today to address these important issues. I understand how important it is to identify alternatives to incarceration, having walked a beat as a New York City police officer and after working in the criminal justice field for 35 years. We cannot arrest our way out of our Nation's drug problems. It is vitally important, therefore, that we stop the revolving door of the criminal justice system and provide alternatives to incarceration. The *2010 National Drug Control Strategy* reflects this premise. It is balanced and comprehensive – recognizing that prevention, treatment, and enforcement are all essential components of an effective approach to addressing drug use and its consequences. Due to the desire to reduce recidivism, the high cost of incarceration, and budgetary constraints being felt at all levels of government, it is important that we take this opportunity to explore new approaches and expand proven efforts to address drug use and its consequences.

The *2010 Strategy* places an unprecedented focus on highlighting the importance of alternatives to incarceration. As our *Strategy* attests, there are more alternatives to incarceration available in our criminal justice system than ever before. While budget realities have driven some of these alternatives, in many cases, cooperative ventures among human service, criminal

justice, and community groups have led to these innovations. Therefore, these alternatives are not solely the province of the criminal justice system. Instead, for these programs to be effective, they also necessitate the involvement of other community and governmental actors. I will discuss several alternatives to incarceration today, including: drug and community courts, drug market interventions, and testing and sanctions programs. In recognition of the links between substance use and crime, treatment for offenders has been part of the *National Drug Control Strategy* for many years, as a combined effort to reduce threats to both public health and public safety.

The current *Strategy* stresses the importance of prevention, treatment, and enforcement. These necessary components comprise a common-sense approach to deterring young people and adults from using drugs and, as is too often the case, becoming involved with the juvenile and criminal justice systems.

The juvenile justice system is built on the belief that youth have the potential to change and grow, but, unfortunately, young people are cycling in and out of state and local systems on a regular basis. To keep young people from cycling through the juvenile justice system or, worse, entering and cycling through the adult system, early intervention and evidence-based approaches are critical. Youth should not only be screened and treated for substance use problems, but also for unmet emotional, behavioral, and academic needs. Protocols for screening, intervention and referral to treatment, and necessary services and programs must be supported to change risky and delinquent behavior and, in turn, stop further involvement in the juvenile justice system. These services should be available throughout the system, whether at diversion, pre-adjudication, post-disposition, or within a juvenile correctional setting or at re-entry. In the FY 2011 Budget proposal, $4 million is requested by the Department of Justice to improve treatment programs

within the juvenile justice system through innovative diversion or re-entry programs. Because of the multidisciplinary nature of the problem, state and local juvenile justice, public health and behavioral health systems must collaborate with school districts, youth job training entities, and other youth services organizations to support positive youth development. ONDCP, the Department of Health and Human Services, the Department of Labor, the Department of Education and other Federal Agencies, through the Coordinating Council on Juvenile Justice and Delinquency chaired by the Attorney General, and other interagency collaborations will support the development and expansion of effective substance abuse, mental health treatment, and youth development programs in the juvenile justice system.

Prevention

While "Alternatives to Incarceration" is the topic of this hearing, no conversation about the intersection of crime and drugs is complete without a discussion of the directly related concept of prevention. The Administration's *National Drug Control Strategy* seeks to prevent individuals from abusing drugs and ever becoming addicted. Prevention helps limit involvement with the juvenile or criminal justice systems.

Research and experience have helped us understand the importance of supporting communities in identifying and responding to the unique nature of their local drug problems. As we provide the training and technical assistance necessary to assist communities in implementing effective prevention strategies, we hope to see more communities strengthened and more lives saved. Major efforts include:

- Creation of a national, community-based prevention system – referred to as Prevention Prepared Communities – to protect our adolescents;
- Continued development of Drug Free Community coalitions;

- A new, National Youth Anti-Drug Media Campaign;
- Grants to assist state and local educational agencies in the development and implementation of a comprehensive set of programs and services.

In the Administration's FY 2011 Budget proposal, $1.7 billion in resources have been requested to support a variety of education and outreach programs aimed at preventing the initiation of drug use, representing a 13.4 percent increase over the FY 2010 enacted level. The Administration has requested $85.5 million to support the Drug Free Communities program and $66.5 million to support the National Youth Anti-Drug Campaign in FY 2011.

Early Intervention and Treatment

Another important component of providing "front-end" alternatives to incarceration is facilitating effective early intervention for individuals with drug problems. Studies indicate most healthcare spending related to substance abuse goes to the avoidable, catastrophic consequences of addiction, rather than to its treatment. For approximately 23 million Americans, substance use progresses to the point that they require treatment. This is roughly the same number of American adults who suffer from diabetes.

Addiction is a chronic, complex disease, both psychological and biological in nature. Addiction should be managed in the same way as other chronic conditions. Unfortunately, there are some major differences between those who suffer from addiction and those who suffer from other chronic health conditions. Often, people who are addicted do not recognize their need for treatment. Interventions, whether delivered in a clinical health setting or in a criminal justice context, connect people who would not otherwise seek treatment with the help they need. Furthermore, drug use is frequently associated with criminal activity. Unfortunately, the criminal justice system is often the only environment where an individual will receive treatment

and be strongly motivated to reduce or eliminate their drug use. Therefore, while it is our hope that an individual can avoid involvement in the criminal justice system, if their substance abuse problem and behavior results in criminal activity, it is important that the criminal justice system be able to treat the disease of addiction. For this reason, the FY 2011 budget requests $3.9 billion for the entire Federal government's treatment efforts.

Criminal Justice

Unfortunately, even the best prevention, intervention, and treatment efforts may not help every person. For some, drug use results in criminal and delinquent behavior, disrupting family, school, neighborhood, and community life in fundamental and long-lasting ways. Currently, more than 7 million adult Americans are under supervision by the criminal justice system. Two million are incarcerated and 5 million are on probation or parole. Fifty percent of inmates were active drug users at the time of their offense; nearly one-third of state prisoners and a quarter of Federal prisoners committed their crimes while under the influence of drugs.[1] The criminal justice system plays a vital role in reducing the costs and consequences of drug crimes, not just by incarcerating serious offenders who threaten the safety of the community, but also by providing a powerful incentive to address drug use before it escalates into a costly, and life threatening addiction. It is critical for drug-involved probationers and parolees to succeed and, in turn, break the cycle of recidivism. In order for probationers and parolees to be successful under community supervision, treatment needs to be of high-quality and readily accessible within the community. That is why, in FY 2011, the Budget proposal for the Department of Justice includes $10 million for prosecution-led drug treatment alternatives to incarceration. The FY 2011 Budget proposal for the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) also includes $4.6

[1] Bureau of Justice Statistics, 2004: http://bjs.ojp.usdoj.gov/content/dcf/duc.cfm

million for the Adult Criminal Justice Treatment program, a grant program that addresses the gaps in substance abuse treatment for adults under community supervision.

The *Strategy* highlights several key principles to breaking the cycle of drug use, crime, delinquency, and incarceration:

- Provide communities with the capacity to prevent drug-related crime;
- Develop infrastructure to promote alternatives to incarceration when appropriate; and
- Use community corrections programs to monitor and support drug-involved offenders.

Alternatives to Incarceration

The majority of drug-involved offenders are in state correctional systems. In addition, most low-risk State offenders are sentenced to probation and placed in the community. Many are referred to programs that are alternatives to incarceration. These alternatives include drug court, residential treatment programs, testing and sanctions programs, and programs that use monitoring devices. These offenders remain in their communities unless they violate the terms of their probation (e.g., missed or positive drug tests or missed treatment sessions). Depending on the violation, the probationer may receive more stringent restrictions, or, if arrested on another offense, may have his or her probation revoked and be placed in jail or prison for a specific length of time. The Federal government promotes innovation and supports promising approaches employed in state systems, the primary correctional entity for drug-involved offenders.

A key to effectively addressing drug-involved offenders within the criminal justice system is to properly assess offenders to determine the most appropriate approach to simultaneously deal with their criminal activity and their substance abuse problem(s). Regardless of what is chosen, every approach must have a continuum of responses. There are a

range of promising initiatives for drug-involved offenders throughout various stages of the juvenile and criminal justice systems. The following are some of the innovative programs being implemented.

Pre-Trial/Post-Booking Diversion

Diversion initiatives have expanded greatly over the past decade, and include a variety of programs at all points of the system: pre-booking, post-booking, court-based, deferred entry of judgment, and even those focused on special populations, such as women with children. Some jurisdictions have allowed offenders with a drug use disorder, upon arrest, to be immediately diverted to alternative programs. Front-end efforts that direct individuals with substance use disorders to community-based treatment have proven promising in treating behavioral health disorders and reducing the likelihood of recidivism.

Specialty Courts

Drug courts combine assessment, judicial interaction, accountability, monitoring and supervision, graduated sanctions and rewards, and treatment and recovery support services. Numerous evaluations over many years have shown drug courts are cost-effective alternatives to traditional incarceration. Data also indicates drug courts prevent most offenders, who successfully complete their individualized programs, from committing new crimes and returning to drug use. The President's FY 2011 Budget request provides for expansion, in scope and size, of such problem solving courts, and we should concentrate efforts on increasing their impact on high-risk, high-need offenders who may be prison-bound, and who, due to continuing substance abuse and criminal activity, continue to cycle through the criminal justice system. In an unprecedented longitudinal study that accumulated recidivism and cost analyses of drug court cohorts over 10 years, Northwest Professional Consortium research found drug courts may lower

recidivism rates (re-arrests) and significantly lower costs. This research found that when comparing drug court to traditional case processing, there was an estimated savings of $1,392 per drug court participant and savings of $6,744 for costs associated with outcomes, for a combined savings of $8,136 on average.

Another type of specialty court is community court. These problem-solving courts can effectively serve the needs of misdemeanant drug-using offenders. Community courts are neighborhood-focused courts that address local problems, including misdemeanor drug possession, shoplifting, vandalism, and assault. Like drug courts, community courts link addicted offenders to judicially monitored drug treatment, and they make use of a broader array of mandates, such as job training and community restitution. These courts strive to create new relationships with neighborhood stakeholders, such as residents, merchants, churches, and schools. Furthermore, they pilot new and more proactive approaches to public safety, rather than only responding to crime after it has occurred.

The Red Hook Community Justice Center, located in Brooklyn, New York, is a great model. As the country's first multi-jurisdictional court, it addresses an array of neighborhood problems – drugs, domestic violence, and landlord tenant disputes. One judge handles all of these matters, and justice is supported by various sanctions, drug treatment, and mental health services.

The Administration supports locally driven drug and community courts and will continue to support approaches that ensure offenders are matched with the appropriate court. For example, veterans' courts have taken root in several jurisdictions across the country. Veterans' courts meet the unique needs of veterans, while matching them with services to assist them on the road to recovery from substance abuse.

The FY 2011 Budget request contains funding totaling $56.4 million for substance abuse treatment activities in drug courts in the Department of Health and Human Services budget (an increase of $12.5 million over the FY 2010 enacted level) and $57 million for drug, mental health, and problem-solving courts in the Department of Justice's budget. This represents a total Federal investment of $113.4 million.

Community Corrections

Community corrections represent a major intervention opportunity. Five of every seven offenders under criminal justice supervision are in the community on probation or parole. Community supervision is an alternative to incarceration with limited services. A community corrections program that is unable to address an offender's substance abuse issues only perpetuates recidivism and incarceration. Recently, however, local community supervision initiatives have been established that aim to improve the rehabilitation of probationers and parolees in their communities by employing swift and certain sanctions for positive drug screens, as well as implementing other evidence-based practices.

Testing and sanctions programs for positive drug screens provide new opportunities to curtail crime, drug use, and its associated consequences among community corrections populations. "*Managing Drug Involved Probationers with Swift and Certain Sanctions, Evaluating Hawaii H.O.P.E.*," an evaluation by Drs. Angela Hawkins and Mark Kleiman, reveals promising results for an innovative community supervision program for both high-risk and general population probationers. Other jurisdictions, such as Lincoln County, Oregon; Fairfax County, Virginia; and Anchorage, Alaska are initiating pilot community correction programs with testing and sanctions.

Another community corrections protocol is Delaware's Department of Corrections

Decide Your Time program, which also applies deterrence through certain and swift apprehension and response. Supported by ONDCP, the National Institute of Justice awarded a grant to the University of Delaware for a project titled, "Evaluating a Drug Testing and Graduated Sanctions Program in Delaware: A Randomized Trial." The purpose of this research is to inform and improve criminal justice and public health policy and practice regarding relapse, violations, and recidivism among chronic drug-using offenders in the community.

The program is for serious offenders serving intensive supervision sentences. Those who remain drug free transition to less-intensive levels of supervision, allowing resources to be focused upon those in need. Failed urine tests result in sanctions that graduate from more frequent testing, to curfew, and ultimately, brief incarceration. In cases of non-compliance, program participants undergo a reassessment of treatment and other service needs. Outpatient drug treatment is mandated after repeated positive drug tests, and treatment modalities, including long-term residential services, are available.

Another program is South Dakota's 24/7 Sobriety Project. Devised by the South Dakota Attorney General's Office, 24/7 is a court-based management program designed for repeat driving-under-the-influence offenders. This program also utilizes swift and certain sanctions. A variety of mechanisms are used to ensure abstinence, including: twice-daily breath testing for alcohol, use of an ankle bracelet to monitor alcohol consumption, and random urine testing for other drugs.

In the instance of positive drug tests, offenders are taken into custody immediately and brought to court within 24 hours. Repeat violations lead to increased periods of incarceration and the revocation of any pretrial release. Results have been encouraging, and the North Dakota Attorney General's Office began its own pilot in January 2008 and hopes to expand it Statewide.

We monitor these promising initiatives to determine their effectiveness and provide information to the criminal justice community to assist them in modifying their existing programs.

States are also reconsidering how to effectively manage drug-involved offenders outside correctional facilities. As the Pew Center on the States reports in its publication, "1 in 31: The Long Reach of American Corrections," a number of States, including Texas and Kansas, have initiated justice reinvestment programs, while States such as Arizona, Michigan, Pennsylvania, Indiana, and Vermont are considering such approaches. The outcomes are promising. As reported by the Council of State Governments in its publication, "*Justice Reinvestment: An Overview,*" in Texas, the legislature reinvested $241 million to expand the capacity of substance abuse and mental health treatment and diversion programs, and to ensure that the release of low-risk individuals is not delayed due to lack of in-prison and community-based treatment programs. These States are examining ways to redirect prison funding to provide for community supervision of low-risk offenders. The additional funding would improve the quality of supervision and services needed to appropriately manage these offenders in the community. Unfortunately, the budget crises many states are facing are forcing them to make difficult decisions regarding corrections funding. Initially, funding alternatives to incarceration can represent a significant additional cost. However, over time, high-quality alternatives to incarceration will result in reduced drug use, crime, delinquency, and incarceration, ultimately resulting in long-term net savings.

I am also encouraged by Congress's interest in seeking alternatives to incarceration by supporting demonstration projects that develop probation programs with the goal of reducing drug use, crime, and recidivism by requiring swift, predictable, and graduated sanctions for non-compliance with the conditions of probation.

Developing and sustaining better community supervision programs with intense supervision, quality and accessible treatment, and other necessary services would facilitate successful supervision of these offenders in a community setting. More importantly, it will improve an offender's ability to succeed and avoid cycling back into the criminal justice system – which is the ultimate goal of corrections.

Drug Market Intervention

Not every drug-related offender has a substance abuse problem that is best addressed by treatment or public health interventions. Some are caught in the cycle of drugs and crime because of their role in drug markets. While prison sentences may be appropriate for some, in certain circumstances, it produces only short-lived results at high costs. Moreover, conditions resulting from the drug market activities persist in threatening the community. Drug market interventions (DMI) that attempt to divert drug dealers from further involvement in the drug trade, working in concert with traditional law enforcement techniques, are an emerging practice in this area.

Under the DMI model, the most violent offenders are prosecuted and low-level offenders are given the option to change their behavior or face prosecution. They are provided a variety of services to assist them in transitioning to a crime-free life style. Many communities, discouraged by the seemingly never-ending cycle of drug dealing and violence, followed this new multi-pronged operational plan, piloted in High Point, North Carolina. The operational plan addressed individual geographic drug markets, directly engaged drug dealers, their families and communities, created clear and predictable sanctions, offered a range of community services and help, and, perhaps most important, established community standards for acceptable behavior. Several cities are in the process of evaluating initial results. Training on the DMI has taken

place, and the Department of Justice is in the process of replicating and evaluating these efforts, and reviewing and funding DMI efforts will remain a priority area for exploration.

Conclusion

The Federal Government's role in these efforts is to ensure Federal assistance promotes evidence-based, effective, and long-term approaches, require evaluations to determine program effectiveness, and highlight model programs.

Drug courts have been evaluated for approximately 20 years. Based on these evaluations, we have seen drug courts make adjustments and improve their models of operation. This same approach of evaluating and adjusting must be conducted for other promising alternative approaches to incarceration being employed across the country to reach maturity and scalability. This can be done by supporting demonstration projects and pilots, be they pre-trial, deferred entry of judgment, or community supervision. When implemented effectively, the criminal and juvenile justice systems can deter drug use and dealing, reduce drug availability, steer users toward getting the help they need and, as a result, help make our neighborhoods safer. By supporting these efforts, the Federal Government is a full partner with State, local, and tribal governments to reduce drug use and crime, improve the lives of individuals, and stabilize communities through the effective and innovative use of resources.

As reflected in the *2010 National Drug Control Strategy*, combining effective and fair enforcement with robust prevention and treatment efforts will enable us to be successful in addressing drug use and its consequences. Measurable and sustained progress against drug use can only be attained when local communities, state agencies and the Federal Government coordinate and complement their efforts.

I look forward to working with the Committee to address these challenging and important

issues. I recognize that none of the many things ONDCP and my Executive Branch colleagues want to accomplish for the Nation are possible without the active support of Congress. Thank you very much for the opportunity to testify and for the support of the Committee on these vital issues.

Mr. KUCINICH. Thank you very much, Mr. Burch and Mr. Tucker.

I want to acknowledge the presence of Congressman Elijah Cummings, who a few years ago opened up this area of inquiry in the Congress, and his city of Baltimore is doing much to try to bring about diversion from the criminal justice system into rehabilitation. So I appreciate Mr. Cummings' presence here.

We are going to have the first round of questions. We will probably have two rounds of our panel.

To both Mr. Burch and Mr. Tucker, the Conference of Chief Justices has advocated expanding drug court funding to $250 million and to distributing this funding to the States in a block grant program. Do you believe that the current evidence on drug court effectiveness warrants expanded funding, or do you believe that a block grant program is the best way to administer drug court grants? Mr. Burch.

Mr. BURCH. Thank you, Mr. Chairman. I appreciate the opportunity to address that question. We have certainly met often with the Conference of Chief Justices, and we appreciate their support for the expansion of the drug court program. We certainly have a lot of respect for their views and their input. They have shared with us some of their concerns about greater coordination of our efforts with the efforts in the State, and we will certainly continue to do that.

Respectfully, however, we don't agree that a block grant program is the best way to administer these funds.

Mr. KUCINICH. Why not?

Mr. BURCH. What we did this year, sir, after the Conference passed a resolution supporting this effort, we set aside some resources in the drug court grant program to test this approach. We offered for States to come in, apply for essentially a block of funding under the drug court grant program that they could then administer to local jurisdictions within their State.

To our somewhat surprise, we only received six applications from around the country for that effort, which demonstrates to us that this may not be the best way to go.

Mr. KUCINICH. Mr. Tucker, do you have a response to that?

Mr. TUCKER. I would, given my newness to the office, but more importantly deferring to Mr. Burch, where they have experiencing in moving block grant funds to the local jurisdictions——

Mr. KUCINICH. Let me do this, then. Mr. Tucker, your testimony acknowledges the hurdles that many cash-strapped States face in implementing alternatives to incarceration. Because even over time the result is net savings, at the front end, establishing alternatives to incarceration can be costly. Is there a role for the Federal Government to incentivize States to set up programs through grants, and is the ONDCP working with Congress to encourage States to initiate such justice reinvestment and community supervision programs?

Mr. TUCKER. The answer briefly is yes. Without a doubt. I think there is no question that we want to drive funding to local jurisdictions. Pretty much everything that we think about with respect to how to deal with drug enforcement, drug treatment, prevention issues is very much a local issue, particularly as it relates to prevention. So to the extent that we can get funds down to the juris-

dictions where it is most needed, obviously I agree with that premise.

Mr. KUCINICH. Let me do a followup, if I may. We just have 5 minutes each. So I am trying to make sure I get your insight on a number of different areas.

As a followup, does the Department of Justice and ONDCP support modifications of the Federal Drug Court authorizing statute that would replace the categorical exclusion of violent offenders from drug courts with a procedure by which local drug court teams would have the responsibility to determine the class of offenders that should be excluded from drug courts because of their criminal history? Would you like to comment on that, Mr. Tucker?

Mr. TUCKER. Sure. The emphasis seems to be, in your question, on violent offenders. The research, as far as I know, suggests that drug courts have had some success in dealing with high-risk, high-need defendants. So to that extent, yes, it is certainly an idea worth considering. I don't know at this point in time how that would be implemented. I think you are correct that it would be left up to the local jurisdictions and the judges in those local courts to make those determinations.

Mr. KUCINICH. Mr. Burch.

Mr. BURCH. I would agree with Mr. Tucker, the research is clear on this point. We don't think categorical exclusions or inclusions are the way to go. This is a local issue. We can't risk public safety. But the research is clear on this. We need to do a better job of getting high-risk, high-need in.

Mr. KUCINICH. Thank you. My time is expired. I am going to recognize Mr. Jordan for 5 minutes. You may proceed.

Mr. JORDAN. Thank you, Mr. Chairman.

Thank you both for being here and for the work you do. Mr. Tucker, we appreciate your background in law enforcement, and appreciate Mr. Kerlikowske, the times that he has come before us and talked with the chairman and myself and the full committee. We appreciate his work.

Mr. Kerlikowske said in a Senate Judiciary hearing back in March of this year that in 2008, over 23 million Americans 12 and older needed treatment for some type of illicit drug or alcohol use problem, but less than 10 percent received the necessary treatment for their respective disorder.

Yesterday we learned in a hearing on the same general subject from Mr. Ford at GAO that in 10 years, because I asked him the question, I didn't know the answer, I just asked the question, has GAO done any studies on how effective our treatment programs are. So if you kind of cut to the chase, only 10 percent of the folks who have a problem are getting some kind of treatment. And we have no idea how effective the treatment is that small percentage are actually receiving.

The folks who get, who are actually put in prison, how many of the incarcerated individuals for a drug offense in our prisons are getting some type of treatment? Probably Mr. Tucker, I would assume, but we can go to both of you.

Mr. TUCKER. Sure. Well, I don't think enough. I don't know the exact numbers. But I think that is our challenge. The data that you

have heard and from other sources suggests that we are not doing enough.

Mr. JORDAN. I think it gets us to the obvious question, if we are looking at alternatives to incarceration, that all makes sense if they are non-violent and that is the best way to help people. I get that. But if we are only getting 10, 11, 12 percent, I don't know. Are we really going to go down that road? We have them there, they are not getting treatment right now.

Mr. TUCKER. I think the point is that we have to figure how to do more. Clearly we need to do more. And I think we need to figure out how to do more both in terms of providing the resources and to your point earlier, making sure that whatever treatment is provided and however it is provided that the vehicles we use are effective and we are getting to the right population.

Mr. JORDAN. Let me ask Mr. Burch, then I will followup.

Mr. BURCH. As it relates to identifying children with those kinds of needs, I think we need to be more creative about how we do that. One of the examples of that is, we are training school resource officers now in how to identify children with those kinds of special needs, and then link them up with the treatment that is available. Because that is often the issue at that age.

In terms of residential treatment, I just want to thank the Congress for responding to the President's call to double the funding through the Residential Substance Abuse Treatment Program. We are now providing States $30 million a year, State departments of correction, to provide residential treatment for those who are incarcerated. That is on top of our investments. Thanks to Congress for responding with the Second Chance Act, a $100 million that is made available to serve offenders and to get them the treatment they need.

Mr. JORDAN. With respect to treatments that actually work, for the percentage we are giving some treatment to, HHS agency, Substance Abuse and Mental Health Services Administration [SAMHSA], has stated that "the beneficial role that faith and spirituality play in the prevention of drug and alcohol abuse and in programs designed to treat and promote recovery from substance abuse and mental disorders has long been acknowledged." Would both of you agree with that statement? Faith-based treatment is effective, would you agree with that statement?

Mr. BURCH. I'm sorry?

Mr. JORDAN. Would you agree with the statement, and this is according to SAMHSA, has stated, "The beneficial role that faith and spirituality play in the prevention of drug and alcohol abuse and programs designed to treat and promote recovery from substance abuse and mental disorders has long been acknowledged." Would you agree with that statement?

Mr. TUCKER. Actually I am not sure I understand the statement.

Mr. JORDAN. I will make it simple. Do you believe that faith-based treatment programs, do you think they are effective in helping people with their drug and alcohol problem?

Mr. TUCKER. I think there are multiple ways in which treatment can be applied.

Mr. JORDAN. The question was, do you think faith-based programs, this is according to HHS, they seem to think so, do you think so?

Mr. TUCKER. I think if they have tested it and they have had some success, I mean, I think treatment is delivered in a number of different modes in different places around the country. If faith-based, if the organization happens to be a faith-based organization and their treatment modality is effective, then I would say, yes, I agree with the statement. But I think there are multiple ways in which treatment takes place.

Mr. JORDAN. Mr. Burch.

Mr. BURCH. I am not familiar with the research specifically. But I think that the President and others have said that there is clearly a role for faith-based organizations and community-based organizations for those who want it in this recovery. So we support that, and we have worked with that for a while.

Mr. JORDAN. OK. Mr. Chairman, I have a followup on that.

Mr. KUCINICH. The Chair recognizes Ms. Watson.

Ms. WATSON. I mentioned before my State of California started one of the largest treatment diversion programs by passing Proposition 36 by popular referendum. Unfortunately, Proposition 36 has not allowed us to significantly reduce the cost of our correction system, because one quarter of the offenders who have accepted the Proposition 36 bargain never appeared for treatment. And then only one third completed it.

So what do you think California needs to do to improve the level of compliance with Prop 36? Should they incorporate any best practices from Hawaii's Opportunity Probation with Enforcement, that is the HOPE program? And given the severe budget crisis that we face in California, do you think the State has the will and resources to successfully reform the Proposition 36 program? I guess I could answer that myself, but let me start with Dr. Tucker.

Mr. TUCKER. I can't speak to the issue of the State's will. But with respect to the parts of the program in California that don't seem to work effectively with respect to the success rate, I think it is important to look at what is happening in Hawaii, certainly. But we can look other places as well. I think there are a number of opportunities around the country to look at places that have been effective and have had high success rates. Drug courts, certainly, the research, as we have already mentioned, have been very successful in keeping the recidivism rates down, for example, over time.

So I think it is worthwhile, when we try these experiments, to evaluate them as we go. And if they are not working, to think about ways in which we can fix the parts that are not effective.

Ms. WATSON. My colleague mentioned faith-based. Sadly, those who are hardly addicted don't end up in these faith-based programs. These are the ones we would like to lure in. But it has been something that is elusive thus far.

I would like to ask Mr. Burch, in your testimony you stated that encounters with law enforcement play a critical role in whether or not people with mental illness or co-occurring disorders, such as mental illness and substance abuse, are identified and directed to appropriate treatment instead of simply cycling them in and out of

our jails and prisons. So what is being done on the Federal level to encourage collaboration between the police and the mental heath community?

Mr. BURCH. Thank you so much, Congresswoman, that is a wonderful question. I am pleased to be able to respond. Through our Justice and Mental Heath Collaboration program, we have been working together with a number of different organizations, among them the National Association of Chiefs of Police, to begin to develop models that can be replicated around the country for crisis intervention to give law enforcement officers that are on the beat the tools that they need to be able to respond to the individuals that they encounter, under the premise that having a person enter the justice system for treatment is simply not the best answer and we can do better.

And we can do better by giving law enforcement the tools they need to know how to recognize it, and then how to divert it locally. And that training has been very successful. We have seen it be replicated not only in individual cities and towns, but also individual States now have taken it on and replicated that training for their entire public safety response core, if you will, not only law enforcement, but also EMTs, for example. Georgia is one example of where that is happening.

So there is great news to report and we are making a lot of progress.

Ms. WATSON. Well, maybe we need to improve the level of understanding of these particular treatments that seem to be effective. We have to some way get that knowledge out there.

I would like to go on, Mr. Burch. You also stated that the Bureau of Justice Assistance is directing $57 million in funding for problem-solving courts in fiscal year 2010 and has requested the same amount for fiscal year 2011. And compared to traditional criminal justice proceedings, the costs are on average $1,392 lower for drug court participants and can get to a savings of as much as $12,218 if recidivism, victimization and other long-term societal costs are factored in as well.

Given the savings that these alternative courts offer and their potential positive impact on individuals, families and communities, it is critical that there are consistently available alternatives to incarceration for those who could benefit. So are you confident that the $57 million is enough to provide comprehensive access to problem-solving courts for all who could benefit from them? And when you developed the request for $57 million for fiscal year 2011, did you take into account the increasing budget constraints of our States and local communities?

Mr. BURCH. Thank you, Congresswoman. Yes, we are taking into account the economic situation that exists in the States and local jurisdictions in everything that we do.

In developing the budget proposals that have been sent forward, obviously the economic conditions and situation that we are in is something that we have to take into consideration. But we also look at the numbers of applications that we are receiving from local jurisdictions to replicate these programs. In the last couple of years, we have been able to fund almost every responsive applica-

tion that has come to us for drug courts or other kinds of problem-solving court programs.

That does not mean that we could not use additional resources, if appropriated, to provide to additional communities. But it does indicate to us that we are providing the responsiveness that we need to provide on this, and that we need to continue to work with communities to address these categorical exclusions that are addressing the people that are able to get into these alternatives. That seems to be a big issue, as it relates to capacity.

Ms. WATSON. Thank you, and thank you for the extra time, Mr. Chairman.

Mr. KUCINICH. The gentlelady is welcome.

The Chair recognizes Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Gentlemen, thank you for being here today. Let me just ask you, in Baltimore, we have had a lot of success with our drug court. As a matter of fact, it has probably proven to be the most successful thing I have seen. First of all, I guess it is because the judge has a hatchet over the head of these folks. They know that if they mess up, they are going to suffer the consequences.

I think the other piece is that it is comprehensive, helping them to find jobs, get drug treatment, the whole bit. There are certain elements that seem to be of certain significance as alternatives to incarceration, that is so that the person, the defendant, most benefits, not just society, but the person benefits. What elements would you say seem to yield, that you have noticed that programs have that seem to yield the greatest benefit to the defendant? Both of you look like you are lost. What is wrong? I thought maybe I was in the wrong hearing or something. [Laughter.]

Mr. TUCKER. Let me respond to that. I think we are talking about providing, to the extent that the person has a drug problem, we want to provide treatment. It is important. And that treatment has to be regular. We have to drug test folks to make sure that they are staying clean. We have to, if they are leaving and returning to our streets, to our communities, then we have to make sure that they are, that treatment can be continued as part of their recovery. That is really critical.

And you mentioned already what I call the wrap-around services, this notion that you don't want to leave these folks stranded. You want to make sure that they have something to help them stand up once they are back in the community. Those types of services have to do with jobs, they have to do with, if we are talking about juveniles, it has to do with making sure that they can cycle back into school to the extent that they are not ready, that they haven't graduated.

But whatever it takes in terms of those wrap-around services, that is what I think is important to help stand these folks up. That is why I think drug courts who provide those kinds of services and recognize that they have a link to service providers that can get support for these individuals once they are back in the community really is an effective way in which to proceed.

Mr. CUMMINGS. I am going to get to you in a minute, Mr. Burch, but I just want to throw this out. I was sitting and listening to you, and I was thinking to myself, alternatives may very well be a good

thing. Because I will tell you, one of the things that has always bothered me as a lawyer and just as a citizen is how somebody can go into prison and come out worse off than when they went in. In other words, the dirty little secret is that sometimes that are drugs floating around in the prisons.

See, people don't like to talk about that. But that is serious. And so if you have drugs in the prison, I mean, if you really think about it, if you don't have drugs in the prison, what does that mean? That means somebody is doing some serious cold-turkey, because that is all they can do.

But then when you see people come out of prison, still drugged up and in some instances worse off than when they went in, that is an uncomfortable subject, but it is real. I live in the inner city of Baltimore, so I see that. So I am just, it kind of bothers me that sometimes we don't address those kinds of issues. You don't have to talk about it, but it is something that people don't deal with, and it is real.

And we have now seen in the Baltimore area more and more indictments coming out for folks who work in prisons. I am not knocking, every headline tomorrow will be Cummings knocks security guards, I am not saying that. I am just telling you what I have seen happen and I think it is happening all over the country, a few bad apples are letting drugs flow into these prisons and it is very, very sad.

So then you say to yourself, well, maybe it is better that the person be on the outside to get the kind of treatment that they need or what have you. You can comment on that if you want, Mr. Burch. Or do you want to comment, Mr. Tucker?

Mr. TUCKER. I agree with you that is a reality. We support, one of the things that we are trying to do here is break the cycle. So we have to think comprehensively. So we focus on drug use, we focus on crime, we focus on delinquency. We also have to focus on incarceration inside the facilities.

So there has to be law enforcement even inside the facilities looking for drugs. The drug trafficking happens inside as well as outside. I am as disturbed as you are we recognize that those conditions exist. But it is about additional law enforcement, I think both at the State level and the Federal level, the institutions spend a lot of time focused on law enforcement inside the institutions, conducting inspections, searches, drug testing and so forth. Those kinds of activities should continue.

Mr. CUMMINGS. Mr. Chairman, I see my time is up. Thank you.

Mr. KUCINICH. We have a vote on, but what we are going to do is give Mr. Davis an opportunity to ask his questions, which will complete the first round. We will recess after Mr. Davis for two votes, perhaps a half hour. Then we will come back and go to the second round and we will get to the next panel after that. I appreciate everyone's indulgence. We in the committee don't have control over the congressional schedule. But we do want to make sure our committee work is thorough and that we hear from everyone.

Mr. Davis for 5 minutes.

Mr. DAVIS. Thank you very much, Mr. Chairman. Let me just say that I am a real fan of drug courts. I have been for a long time. A good friend of mine, Eugene Pincham, they used to call him all

kinds of things, the hanging judge. But Pincham started years ago of probably going outside the rim of what people expected a judge to do. He just started directing individuals to do certain things. He would give them 60 days to do them and say, come back to my court, let me see how you have made progress. If you haven't made any, I am going to lock you up, I am going to send you down to Menard or wherever. Of course, Judge Pincham died not too long ago. He was recognized as one of the most effective judges around.

Let me ask, how high is the Bureau on coalitions? The development of community coalitions as a real way of reducing recidivism? I have seen some places like in North Chicago, Illinois, and Waukegan, that I consider to have a very excellent community coalition. I have seen something in Bloomington, Illinois, where the Joy Center has put together a coalition of public defender, the State's attorney, the NAACP, the churches, the schools, everybody is a part of their action. How does the Bureau feel about that kind of activity?

Mr. BURCH. Thank you, Congressman Davis. I am glad to hear you mention Bloomington, Illinois. In fact, we were involved in working with Bloomington, Illinois, in setting up that group many years ago when they began an anti-gang initiative in that community. That is where that group got started. I don't remember the name of the committee now, but it has been a very innovative group. I think at one time they even started their own business to generate revenues for their program. It is just a great community and a great group of people.

And I am sure Mr. Tucker would like to talk about the Drug-Free Community Support Program that also encourages collaboration. We are 100 percent behind that, and we are thankful to you and others for ensuring that the Second Chance Act also includes this notion as well, and the task force requirements as a part of that program.

We see that, and you have to have that kind of broad-based community support behind every one of these initiatives. As we talked to folks in Virginia earlier this week, in fact, you can't just have one part of the system trying to make change. We have to make change in every part of the justice system, from the front door to the back door and everything in between. All of those people have to be at the table and have to be committed to making change.

So we are 100 percent behind that.

Mr. DAVIS. Thank you very much.

Mr. Tucker, let me ask you, there is an expression of concern on the part of many people that there might be more focus in terms of the drug control policy shifting toward trying to prevent the spread of meth and not as much focus put on, say, crack cocaine in central city areas. I happen to live in the inner city area of Chicago and have lived in a big, urban inner city all of my adult life. Could you just address those two concerns that are being expressed?

Mr. TUCKER. Sure. I think I understand it. I think again, this s a very local kind of issue. Even when I was on the streets as a cop, these same kinds of questions would come up from neighborhood to neighborhood, community to community. The fact of the matter is that depending on what community we are talking about, what State, what neighborhood, what county or whatever, you are going

to have different types of, as it relates to drug trafficking, different types of illegal, illicit substances.

So as you point out, it could be meth in the Midwest, perhaps, as it came across the country or it could be cocaine, it could be heroin, it just depends. So the response is going to be dictated by the threat. So the way in which we do this is, for example, I am responsible for the High Intensity Drug Trafficking Areas, there are 28 of those around the country, 5 along the Southwest border and in a number of other jurisdictions. Those are task forces, Federal, State and local law enforcement offices, constantly looking at, gathering information, looking at the intelligence and then looking at also developing the threat for that particular jurisdiction, wherever it may be.

So that is, I think, the response has to be a function of what the threat is. And then the authorities, the law enforcement officials take the necessary steps to try and intervene.

Mr. DAVIS. Thank you very much, and thank you, Mr. Chairman. I yield back.

Mr. KUCINICH. I thank Mr. Davis. Committee members, we will be back here at approximately 4 o'clock to resume the second round of questions. The committee stands in recess until 4. Thank you.

[Recess.]

Mr. KUCINICH. Thank you very much for your patience and your presence. We are going to go to round two of questioning. To both Mr. Burch and Mr. Tucker, lessons both positive and negative can be derived from the over 1 million participants in Prop 36 that are presumably important to the Federal Government's role in promoting evidence-based, effective, State criminal justice policies. So it seems logical that the Federal Government would be more involved in the evaluation of its effects and perhaps take a position on its success. But it doesn't seem the Federal Government has taken a role.

Do you want to comment on that, Mr. Burch?

Mr. BURCH. Thank you, Mr. Chairman. I think it is correct that I don't think we have a position or have taken a position on that proposition.

Mr. KUCINICH. Do you have any comment on it at all?

Mr. BURCH. Well, not on the proposition itself, sir, but on the general topic of alternatives to incarceration and the things that we can be doing in this area is exactly what we are hoping to do more of this coming year.

Mr. KUCINICH. I thank you. Mr. Tucker, would you agree with that?

Mr. TUCKER. I think so. And again, both as we mentioned earlier in the last session, to the extent that the program that has been established is not working completely as expected and may not be serving the population or getting the results that were expected, then certainly it is important to reevaluate it and figure out what the fixes might be.

Mr. KUCINICH. Now, Mr. Burch, in her written testimony, Professor Hawken notes that over half the criminal justice program designated as evidence-based and the SAMHSA's National Registry of Evidence-Based Programs were evaluated by the program developer. That research shows that outcome analyses are typically

more positive when conducted by those with a vested interest in the program. While I have no reason to doubt the results of the MADCE study on drug courts funded by the Department of Justice, I will note that their principal researchers include prominent advocates of drug courts. What steps has the Department of Justice taken in the design of its new Evidence Integration Initiative to ensure the integrity of the program evaluations?

Mr. BURCH. Thank you, Mr. Chairman, that is a great question. The EII initiative is a broad initiative that will not just focus on one or two evaluations, or evaluations that we have funded or that our partners have conducted. The way that we expect to roll out EII is a very broad-based effort to look at what other organizations have found with regard to evaluations, including entities such as the Campbell Collaboration and others. So it is a very broad look at what the field has found with regard to effectiveness of certain programs. It will not be focused exclusively on those that we have funded or that our partners have implemented.

Mr. KUCINICH. What percentage of those who are currently incarcerated for drug-related offenses do you believe should not be subject to incarceration at all under an ideal criminal justice scheme that balances concern for public safety and the need for deterrence and a sober assessment of direct and collateral harms of incarceration? Mr. Burch.

Mr. BURCH. Thank you, sir. I think it would be hard to put a finger on an exact percentage. But as I noted earlier, I think one of the concerns that we have with where we are today is this categorization of certain types of offenders or needs within certain categories. So what I would advocate for is that we go to a risk assessment based model. We can look at each individual offender to determine what the needs are. And that would tell us which of those folks that are incarcerated really do need to be there and which don't.

Mr. KUCINICH. Mr. Tucker, would you like to comment on that?

Mr. TUCKER. I would agree with Mr. Burch. I think it is case by case. I think that is the simple solution. We have to pay attention to who these individuals are, why they are inside and then make some determination whether or not either we continue to provide them with treatment and services while they are incarcerated for the long term, or under whether certain circumstances it would be appropriate to put them on parole, as an example, to provide services.

Mr. KUCINICH. On the next panel, we are going to have many witnesses who have recommended that we move toward evidence-based sentencing. Sentences based on risk and needs and cost-effectiveness data and not simply on offense-based factors. One witness recommended both the amendment of the U.S. Sentencing Guidelines and that DOJ should make grants to States for them to formulate evidence-based sentencing reforms.

Where are you on the issue of sentencing reforms?

Mr. TUCKER. I understand that the Justice Department, actually the Attorney General, has appointed a panel to take a look at sentencing reforms, and I think appropriately so. So I think it would be wise for us to see what the panel has to say about sentencing

in all its aspects, and then be guided by that in terms of what we do going forward.

Mr. KUCINICH. Mr. Burch.

Mr. BURCH. Yes, sir. I think as it relates to making grants available for States to do this, and recognizing each State, each local jurisdiction may have its own preferences and desires, we are funding efforts, through organizations such as the Justice Management Institute, to go out and provide training and technical assistance to States to go through that process of determining what is evidence-based, what is the smarter approach to sentencing.

And then this year we have offered funding for something called the field initiated innovations parogram. I note that we go a couple of applications from the field to begin applying that funding to change the way the system works in terms of sanctions. Arkansas was one example where we received a proposal like that this year. So there is really, I think, a lot of movement in this direction.

Mr. KUCINICH. Incarceration rates, as I am sure both of you know, in the United States, are much higher than those in Western Europe and other developed nations. Does either the ONDCP or the Department of Justice approach the issue of incarceration for drug offenses in a comparative perspective and analyze the success and failures of other nations' approaches to drug crime and punishment? Mr. Burch.

Mr. BURCH. Thank you, sir. I know that our National Institute of Justice does have an international component where we are looking at what is happening in other countries and how to apply those lessons learned to this country. The Bureau of Justice Assistance has done the same this year in making a grant award to the RAND Corp. to help us identify similar gains in other countries, particularly those whose justice system looks similar to ours, and helping us understand those lessons learned and the best practices from those nations.

Mr. KUCINICH. Mr. Tucker, would you like to add to that?

Mr. TUCKER. I would just add that I think it is pretty clear that we get, what we have been doing up to now has not been good, nor effective. I think it is why we are here talking about alternatives to incarceration, why the current drug control strategy has this broad approach to thinking about that cycle.

When we talk about breaking the cycle, we are talking about crime, delinquency and incarceration in every respect and as it relates in particular to incarceration, the notion that we recognize that too many people are incarcerated and we are trying to redirect, along with our partnership agencies, including DOJ, to think about ways in which we can get some relief in that respect, both at the front end in terms of keeping people out of the system in the first place, focusing on prevention and looking at ways in which that prevention can impact the most at-risk people, such as young people in particular, but also adults who happen to be using or addicted.

Mr. KUCINICH. I want to talk for a moment about women with children. Women are the fastest-growing segment of the incarcerated population, increasing at nearly double the rate of men since 1985. Among female State prisoners, two thirds are mothers of a

minor child. Children of inmates are five to six times more likely to become incarcerated than their peers.

This makes providing alternatives to incarceration for mothers even more critical than other populations. Your testimony refers generally to diversion initiatives focused on women with children.

What specific actions are being taken to encourage diversion initiatives in this particular group, women with minor children? I would like to hear from both of you.

Mr. BURCH. I will take the first shot at that, if I could, Mr. Chairman. One of the things that we have noticed in examining this issue is the prevalence of mental health issues among women, in particular, in jail, but also in prison. This is something that we want to understand better, because we think this may represent the best point of intervention for us and the best point of being able to divert women from the justice system. So we are working together with the National Institute of Corrections at the Department as well as other organizations to better study this issue. Once we identify those points of intervention, we will then move on them very quickly.

But we also have made a lot of efforts toward making sure that we are providing opportunities to connect those women with their families and children, but also focusing as well on fathers. You may know the White House has an expansive initiative this year with us to focus on fatherhood issues. And we will continue to do that as well.

Mr. KUCINICH. Mr. Tucker.

Mr. TUCKER. No question, we need to do more there as well with respect to this population. And ONDCP as part of our overall strategy is supporting the various programs that exist to facilitate and to create a resource or provide resources that will help us deal with the problem that you just described with respect to mothers and children.

It is, to the extent that children are impacted, we need to make sure that when we are talking about prevention it is clearly, we recognize it is more cost-effective to impact those youngsters as early as possible to prevent them from falling into the same habits of drug abuse that perhaps their parents have.

Mr. KUCINICH. Is there much time being spent going into these institutions and talking to the women about their situation and what is being done to care for their children? What happens? Because the children end up paying a penalty, too.

Mr. TUCKER. Just from my personal experiences in this regard, I go way back. I agree with you, and I recognize that children pay the price because of domestic violence, because of drug use. More recently, as it relates to drug-endangered children with respect to methamphetamine, for example, but also in a much broader context.

So we recognize the impact on children. I know that we currently have a working group that involves a number of the participating Federal agency partners to look at the issue of the impact on children as it relates to drugs, meth in particular. But I think there is a desire to look at it in a broader context as well.

Mr. KUCINICH. Mr. Tucker, just one final question. Your testimony acknowledges the promising result of the HOPE testing and

sanctions community supervision program. How is ONDCP working with Congress and States to further support pilots and demonstration projects of HOPE and HOPE-type programs?

Mr. TUCKER. We acknowledge that HOPE is recognized as a success. We want to look at it in a much broader context. While HOPE has been successful, we are not looking at it in the context of only HOPE, but also other drug courts and other types of programs that provides the same kinds of approaches to dealing with offenders.

So it is, while we recognize that HOPE has had its success, I think we also want to look at it in a broader context, and continue to look at and analyze some of the new models, new jurisdictions that are going to be trying to implement the HOPE model and to see whether or not what happened in Hawaii and how effective it was translates to the same type of success in other jurisdictions.

Mr. KUCINICH. I want to thank both of you for your testimony and for your presence at this subcommittee today. The subcommittee members will have followup questions to present to you in writing. And I appreciate your answering them to help us in our work.

I am going to dismiss this panel and we are going to take a very brief, 3-minute recess while staff prepares the table for the next panel. So again, thank you very much. Your attendance is appreciated. We are going to move to the second panel momentarily.

Mr. TUCKER. Thank you, Mr. Chairman.

Mr. BURCH. Thank you very much.

[Recess.]

Mr. KUCINICH. Thank you very much. We are going to begin the testimony from the second panel. And it is a panel with extensive background in this area. I think we will be moving expeditiously through your testimony. I know that a number of you have commitments that are time-sensitive. This hearing already is about an hour and a half behind schedule.

So I am mindful of that. I think that if all goes well, we could probably get out of here within the hour, if that will work for everyone. That will be my goal. And we have no other votes for this evening, so that gives us a pretty good clear track.

I will begin by making introductions of the second panel of witnesses. Angela Hawken, welcome. Angela Hawken is Associate Professor of Economics and Policy Analysis at the School of Public Policy at Pepperdine University. She taught graduate economics in South Africa before moving to Los Angeles in 1988 to complete a Ph.D. in policy analysis at the RAND Graduate School.

She teaches graduate classes in applied research methods, statistics, crime and social policy. Professor Hawken led the statewide cost-benefit analysis of California's alternative sentencing initiative, Proposition 36, and the randomized control trial of Hawaii's HOPE probation.

John Roman. Mr. Roman is Senior Research Associate in the Justice Policy Center at the Urban Institute, where his research focuses on evaluations of innovative crime control policies and justice programs. He is also the executive director of the District of Columbia Crime Policy Institute where he directs research on crime and justice matters on behalf of the Executive Office of the Mayor.

Dr. Roman is directing several studies funded by the National Institute of Justice, including a national study of the demand for

community-based interventions with drug-involved arrestees. Dr. Roman also manages the national evaluation of adult drug courts, and is co-editor of the cost-benefit analysis in crime control and juvenile drug courts and teen substance abuse. Dr. Roman also serves as a lecturer at the University of Pennsylvania and an affiliated professor at Georgetown.

Douglas B. Marlowe is Chief of Science, Law and Policy for the National Association of Drug Court Professionals, a senior scientist at the Treatment Research Institute and an adjunct associate professor of psychiatry at the University of Pennsylvania School of Medicine. A lawyer and clinical psychologist, Dr. Marlowe has received numerous State and Federal research grants to study coercion and drug abuse treatment, the effects of drug courts and other diversion programs for drug abusers involved in the criminal justice system, and behavioral treatments for drug abusers and criminal offenders. Dr. Marlowe has published over 125 professional articles and chapters on the topics of crime and substance abuse and is editor in chief of the Drug Court Review.

Daniel N. Abrahamson is Director of Legal Affairs for the Drug Policy Alliance, an organization devoted to drug policy and drug law reform. Mr. Abrahamson is co-author of California's Proposition 36, the Substance Abuse and Crime Prevention Act enacted in 2000 and served on several statewide committees overseeing implementation and evaluation of the act.

Mr. Abrahamson has litigated public health matters in State and Federal courts. He has taught interdisciplinary courses on criminal justice and public health at Yale, Fisk, Hastings College of Law, and the University of California Berkeley School of Law.

Ms. Melody M. Heaps founded Treatment Alternatives for Safe Communities, TASC, in 1976, and led it until her retirement as president in 2009. She is currently President Emeritus and a consultant to TASC. Under Ms. Heaps' leadership the agency grew from a small pilot program in Cook County, Illinois, to a $20 million statewide organization providing direct services to 25,000 individuals annually.

Ms. Heaps began her professional career as a community organizer and joined the Southern Christian Leadership Conference as one of Dr. Martin Luther King, Jr.'s staff during the Chicago campaign. She also helped develop and implement the National Institute on Drug Abuse's judicial training curriculum and organized the first national managed care and criminal justice conference. Ms. Heaps has provided consultation services for numerous public and private agencies, including ONDCP, and served on numerous drug policy-related task forces.

Finally, Mr. Harold A. Pollack. Mr. Pollack is the Helen Ross Professor at the University of Chicago School of Social Science Administration and faculty chair of the Center for Health Administration Studies, and is also a co-director of the University's crime lab. He is published widely on the interface between poverty, policy and public health. His substance abuse policy research appears in such journals as Addiction, Journal of the American Medical Association, American Journal of Public Health, Health Services Research and other leading peer-reviewed journals. Professor Pollack has been

appointed to three committees at the National Academy of Sciences.

As we can see, we have a distinguished panel of witnesses. It is our privilege to have you appear to testify in front of this subcommittee.

It is the policy of the Committee on Oversight and Government Reform to swear in all witnesses before they testify. I would ask that you rise and raise your right hands.

[Witnesses sworn.]

Mr. KUCINICH. Thank you. Let the record reflect that each of the witnesses answered in the affirmative.

I would ask that each of you give an oral summary of your testimony. The entire account of your testimony will be included in the record of the hearing. We just want to get a general idea of what it is you are presenting.

I would also like to add for the record that the statements of this particular panel were very thorough, very thoughtful. I want to commend you for that. Much appreciated.

Professor Hawken, you are our first witness on this panel. I would ask that you begin.

STATEMENTS OF ANGELA HAWKEN, PH.D., ASSOCIATE PROFESSOR OF ECONOMICS AND POLICY ANALYSIS, SCHOOL OF PUBLIC POLICY; JOHN K. ROMAN, SENIOR RESEARCHER, JUSTICE POLICY CENTER, URBAN INSTITUTE; DOUGLAS B. MARLOWE, J.D., PH.D., CHIEF OF SCIENCE, LAW AND POLICY, NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS; DANIEL N. ABRAHAMSON, DIRECTOR OF LEGAL AFFAIRS, DRUG POLICY ALLIANCE; MELODY M. HEAPS, PRESIDENT EMERITUS, TASC, INC.; AND HAROLD A. POLLACK, HELEN ROSS PROFESSOR, UNIVERSITY OF CHICAGO SCHOOL OF SOCIAL SCIENCE ADMINISTRATION, FACULTY CHAIR OF THE CENTER FOR HEALTH ADMINISTRATION STUDIES

STATEMENT OF ANGELA HAWKEN

Ms. HAWKEN. Good afternoon, Mr. Chairman. Thank you for the opportunity to testify today.

I would like to discuss the experience of offender management in two States, California and Hawaii, and then end with a short list of recommendations of how the Federal Government might improve offender management with a goal of reducing incarceration.

In the 1990's, hundreds of pieces of legislation were passed in California, all of them tough on crime. Prop 36 was the first measure to turn the tough on crime tide. Under Prop 36, non-violent drug offenders had the opportunity of being sentenced to community-based treatment, rather than to prison or jail, or to probation without treatment.

Keeping drug users out of our jails and prisons made a lot of sense to me, so I was very pleased to be invited to lead the cost-benefit analysis to study the effects of the law.

This work showed that in the beginning, Proposition 36 saved Californian taxpayers a great deal of money, as these drug users were diverted from our prisons and jails. But my enthusiasm for Prop 36 began to dwindle as more and more data showed that

those initial years were a honeymoon period, and very soon the prison diversion dried up. Many probationers made their way back into the prison system.

Why did this policy fail? Many reasons. Under Prop 36, every probationer has to be treated. This is true for diversion programs in general. Every probationer, even probationers without a diagnosable substance abuse condition. With limited treatment resources, if everybody must be treated, this results in a little bit of nothing for everybody. Treatment resources are spread very thin.

There was next to no accountability under Prop 36. Nearly a quarter of the probationers who accepted sentencing and a deferral to treatment never appeared for a treatment session. Only a third of those who did appear for treatment actually completed the program.

A UCLA study asked, what was the consequence for no-show? The modal response, that is the most common response, was nothing. Nothing isn't very motivating.

Proposition 36 was enacted into law as the Substance Abuse and Crime Prevention Act. But the experience was quite the opposite. Criminal activity among this group increased. Even the best of the best, those who made it all the way through their treatment program and had a successful discharge, even this group had high rates of followup arrests and convictions than a comparison group of pre-Proposition 36ers.

Over half of them were arrested on a new drug charge while under Proposition 36, and over a quarter were arrested for non-drug charges. Of those non-drug arrests, about a quarter were for violent crimes against other persons.

There is very little accountability in the system. Compliance under Prop 36 is so poor that when surveyed, 80 percent, that is eight zero, 80 percent of California treatment providers support a change in the program to allow the use of short jail stays to motivate treatment compliance.

There is another little-discussed sad consequence of Proposition 36. When our treatment system is flooded with referrals from the criminal justice system, something has to give. Dr. Ian Hughes' research from UCLA has shown that what gives are those people who entered the system with a self-referral. People who are self-motivated to seek out care are being displaced. We have never studied the consequences of pushing these drug users out of our system. Our expectations are that these are primarily alcohol-individuals, and as you know, alcohol is by far our most dangerous drug. My expectation is a study of this kind would show quite devastating consequences.

Loosening the reins on drug offenders has not provided a meaningful alternative to incarceration in California. As you can tell, I was very disheartened by the Prop 36 data. And just about that time, I heard of a new program in Hawaii that was supposedly transforming probationers' lives. The program was called HOPE, Hawaii's Opportunity Probation with Enforcement. It was designed by a judge, in collaboration with police officers, with probation officers, with prosecutors, with public defenders. Together they tried to resolve the problem.

Revoking probation is very serious. It often results in years, typically months but sometimes years of incarceration, which leaves probation officers with a dilemma. If their probationers are not complying, they have only one of two choices. They can either let those boo-boos go unchecked, boo-boo after boo-boo, typically 16, 17 violations before anything is done, or they can revoke probation. If they revoke probation, the response is usually very draconian, which lets very little in between.

If you have ever had a dog, you will know this is not how you train a puppy. You don't spank them on the 17th puddle. You make sure they understand the consequences at every step along the way. But that is not how we have managed our probationers. We have sent extremely mixed signals to them.

So Hawaii completely redesigned the system of how they handle probation. The probationers are brought into open court and given a warning hearing, where they are told that the conditions of probation are completely unchanged; the only difference from now on is that they will actually be followed through on. There is some honestly injected into the system.

They are also assigned a color that day, and every weekday morning they have to call a hotline. If their color comes up, they have to go for a drug test. If they test positive, they are immediately arrested and taken before a judge and sentenced to a brief stay in jail, typically a few days, on a weekend if they are employed.

When speaking with probationers, we use the language of, I don't use any more, because knowing that I might go to jail tomorrow ruins the high. Ruining the high is a good thing. If they continue to test negative, in other words, good behavior, they get to change their color and they are tested less regularly and ultimately earn their way off of testing entirely.

Under HOPE, probationers only come before the judge if they violate. This is a distinct difference between HOPE and the drug court approach, which helps to save on the judiciary resources, which has very large implications for costs of running the two models.

From the very beginning, we collected data on HOPE with the help of the Attorney General's office. There have now been two evaluations. One of those included an intent to treat randomized control trial. The subjects in a randomized control trial had long histories of criminal justice involvement, long histories of drug use. They averaged 17 priors by the time they entered the study.

The outcomes have been striking. There were large reductions in drug use. By 3 months and 6 months we saw 80 percent, 90 percent reductions in drug use. Comparing HOPE probationers to a control group of probationers as usual, we found large reductions in no-shows, large reductions in arrests, they were slashed in half, large reductions in revocation. That is very important because of what that means for incarceration. There were huge differences in the number of days incarcerated between the two groups.

We have this counter intuitive result that a program that allows swift and certain jail sanctions has an overall reduction, large reduction, in incarceration. We found an average of 130 prison days saved per probationer.

The other advantage of HOPE is that it provides a strategic approach for managing our limited drug treatment resources. I like to call HOPE a behavioral triage model, where we decide who needs treatment based on their observed behavior. And in HOPE, 80 percent of these drug-involved probationers were able to desist from drug use without any treatment whatsoever. What that meant is we could divert 80 percent of the treatment dollars to the 20 percent of the group who really did need care. What that meant was Cadillac-level treatment for those probationers.

What about the probationers? They liked it. Figure 2 of my testimony that I submitted showed a survey of HOPE probationers. Across the board, they give the program high praise. Even those who were surveyed while they were serving a jail sentence under HOPE had positive reviews of the program.

So no doubt in Hawaii, HOPE has been a success. It is showing that probation can indeed be a meaningful alternative to incarceration.

Another important point to note is that HOPE isn't only being applied to drug offenders. It is also letting in people who committed other sorts of crimes while under the influence. So we are seeing many people coming in, property crimes too, and even some violent offenders are being successfully supervised under HOPE.

The HOPE court now oversees 1,600 probationers and it is not a dedicated court. That judge also tries other cases. And the dedicated HOPE court is expected to oversee 3,000 probationers. One court, 3,000 probationers. The cost implications of being able to oversee such a large load successfully are enormous.

At the moment, we are in such trouble, we really do need a mass solution. And a mass solution requires an inexpensive response. HOPE has been shown to be that inexpensive response.

Briefly, we need to replicate this. We have seen it in Hawaii. It has to be replicated on the mainland. We need to see what elements are essential. We just don't know. Ideally, a continuum of supervision, which the others will talk about, where HOPE is on the front end, nice and cheap, moving them into drug courts with its wrap-around services for those who can't survive the HOPE program.

Thank you.

[The prepared statement of Ms. Hawken follows:]

Front-End Alternatives to Incarceration for Drug Offenders

Angela Hawken, Ph.D.
Associate Professor of Economics and Policy Analysis
School of Public Policy
Pepperdine University
Malibu, CA

Testimony prepared for the House Committee on Oversight and Government Reform

July 22, 2010

Probation and parole supervision are intended to serve as an alternative to incarceration: In lieu of a prison term, an offender promises to comply with a set of conditions, and an officer is assigned to monitor enforcement, with authority to report violations to the court or Parole Board for possible sanctions. This avoids the cost of incarceration (and the damage it can inflict on the offender's chances of successfully integrating into law-abiding society) and promises rehabilitative benefits from requiring the offender to live lawfully in his or her home community. Yet high caseloads, a sanctions process that puts large demands on the time of probation officers and judges, the scarcity of jail and prison beds, and the low priority many police agencies give to the service of bench warrants for probation absconders make it difficult to actually enforce the terms of probation, and rates of noncompliance are accordingly high. Drug testing of probationers tends to be too infrequent, test results come back too slowly, and sanctions are too rare, to produce behavior change. And yet when sanctions are made, they tend to be quite severe (months, or occasionally years, in prison), which defeats the rationale for probation as a less costly penalty than incarceration. In some jurisdictions, parole revocation for technical violations (mostly dirty drug tests) are a major source of prison entry.

Over the past two decades, inflation-adjusted expenditure on corrections has more than doubled (Hawken & Grunert, 2010). Concern over the growth in corrections spending has forced policy makers to review less-expensive alternatives to incarceration for drug offenders, reinforcing the importance of community supervision. There has been a dramatic shift in the way in which drug offenders are managed. A large number of states have implemented intermediate-sanctions programs and treatment-diversion programs, which provide drug offenders with the option of receiving treatment in the community rather than serving jail or prison time. A frustrating statistic, however, is that the rates of successful completion of either probation or parole have remained historically stable in spite of the myriad local, State, and Federal initiatives undertaken to improve offender outcomes (Hawken & Grunert, 2010). Disappointing results from treatment diversion programs, such as California's Proposition 36 (the nation's largest diversion program), demonstrate the longstanding problem of compliance in the field of offender treatment: One quarter of the offenders who accepted the Proposition 36 bargain never appeared for treatment, and of those who did enter treatment, only about one third completed it. Compliance under

Proposition 36 is so poor that support among treatment providers for a change in the program to allow the use of short jail stays (to motivate treatment compliance) has grown to 80.1%.[1]

Hawaii's Opportunity Probation with Enforcement (HOPE) provides evidence that re-engineering the probation-enforcement process can yield positive results in terms of compliance with all types of probation conditions, including desistance from drug use, among even heavily drug-involved methamphetamine users (Hawken & Kleiman, 2009). And it achieves these results at a relatively low cost.

What is HOPE?

HOPE is a new strategic approach for managing probationers. The HOPE intervention starts with a formal warning, delivered by a judge or hearings officer in open court, that *any* violation of probation conditions will not be tolerated: Each violation will result in an immediate, brief jail stay. Each probationer with substance abuse issues is assigned a color code at the warning hearing. The probationer is required to call the HOPE hotline each weekday morning. Those probationers whose color is selected must appear at the probation office before 2 pm that day for a drug test. During their first two months in HOPE, probationers are randomly tested at least once a week (good behavior through compliance and negative drug tests is rewarded with an assignment of a new color associated with less-regular testing). A failure to appear for testing leads to the immediate issuance of a bench warrant, which the Honolulu Police Department serves. Probationers who test positive for drug use or fail to appear for probation appointments are brought before the judge. When a violation is detected, the probation officer completes a "Motion to Modify Probation" form and faxes this form to the judge (a Motion to Modify form was designed to be much simpler than a Motion to Revoke Probation and can be completed very quickly). The hearing on the Motion to Modify is held promptly (most are held within 72 hours), with the probationer confined in the interim.[2] A probationer found to have violated the terms of probation is immediately sentenced to a short jail stay (typically several days servable on the weekend if employed, but increasing with continued non-compliance), with credit given for time served. The probationer resumes participation in HOPE and reports to his or her probation officer on the day of release. Unlike a probation revocation, a modification order does not sever the probation relationship. A probationer may request a treatment referral at any time; but probationers with multiple violations are *mandated* to intensive substance-abuse–treatment services (typically residential care). The court continues to supervise the probationer throughout the treatment experience, and consistently sanctions noncompliance (positive drug tests and no-shows for treatment or probation appointments). The HOPE model does not represent a movement against treating drug offenders. Instead, it proposes using treatment resources more strategically, by providing higher-quality, longer-term care to those whose behavior has indicated they are in greatest need of intensive services.

---

[1] See Hawken and Poe (2008). Data are from the 2007 UCLA Provider Survey. The providers (n=87) constitute a representative sample of California treatment providers who serve Proposition 36 clients.

[2] If a positive drug test result is disputed, the probationer is released pending confirmation testing, and given a court date for one week later. These probationers are warned that their jail sanction will be enhanced if positive drug use is confirmed.

HOPE Evaluation Findings

HOPE has been subjected to two evaluations, including a randomized controlled trial of high-risk primarily methamphetamine-using probationers. These evaluations were conducted with support from the National Institute of Justice and the Smith Richardson Foundation. Evaluation findings from both studies show that HOPE probationers have lower drug use, and fewer no-shows for probation appointments, new arrests, probation revocations, and days incarcerated, compared with probationers assigned to probation-as-usual.

In the Integrated Community Sanctions Unit (Honolulu's intensive supervision high-risk probation unit), the rate of positive drug testing by fell 93 percent for HOPE probationers during the first six months (from 53 percent to 4 percent), compared with 14 percent for comparison probationers (from 22 percent to 19 percent). Only 40 percent of HOPE probationers had any post-warning violation within the first year; of those who had one violation, only half had a second violation; of those with two violations, only half (10 percent of the total) a third or subsequent violation. Thus HOPE identified a small minority of probationers who did not desist from drug use under sanctions pressure alone. I refer to this as the "behavioral triage" function of HOPE—the program identifies those most in need of treatment by documenting their actual conduct rather than relying on self-report assessments (see Hawken, 2010). Similarly, we found large significant reductions in no-shows for probation appointments for probationers assigned to HOPE, but no meaningful improvement for the offenders in the comparison group.

A subsequent study was conducted in a general probation unit using random assignment and an intent-to-treat design (i.e., all offenders assigned to the HOPE condition were included in the HOPE group, even if they failed to appear for their warning hearing to formally enter the program). This distinction had important implications for our study, as 30 percent of the offenders who had their probation revoked and were sentenced to an open term under HOPE had never appeared for a warning hearing. The results of the randomized controlled trial (RCT) are summarized in Table 1. There were large reductions in missed appointments, positive drug tests, recidivism, revocation and incarceration days.

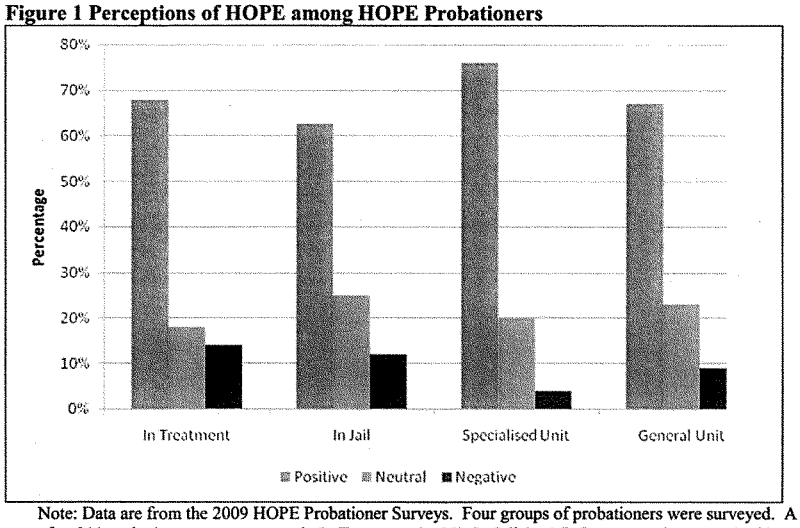
Table 1. Summary of RCT Findings

Outcome	HOPE	Control
No-shows for probation appointments (average of appointments per probationer)	9%	23%
Positive urine tests (average of tests per probationer)	13%	46%
New arrest rate (probationers rearrested)	21%	47%
Revocation rate (probationers revoked)	7%*	15%
Incarceration (days sentenced)	138 days	267 days

**Thirty percent of the HOPE probationers who had their probation revoked had never appeared for their HOPE warning hearings. The revocation rate among those who appeared for a warning hearing was 5 percent.*

Outcomes were robust across judges and across probation officers (similar outcomes regardless of their perceptions of the program). Our evaluation included surveys of key staff involved with implementing HOPE, and the HOPE probationers themselves. We found positive general perceptions of HOPE, with the highest levels of satisfaction reported by judges and probation officers. Four groups of probationers were surveyed (see Figure 1): in jail; in treatment; in community under supervision of the Specialized Unit; and in community under supervision of the General Probation Unit. Across supervision conditions, probationers reported positive general perceptions of HOPE.

Figure 1 Perceptions of HOPE among HOPE Probationers



Note: Data are from the 2009 HOPE Probationer Surveys. Four groups of probationers were surveyed. A total of n=211 probationers were surveyed. In Treatment (n=28); In Jail (n=16); In community supervised by Specialized Probation Unit (n=50); In community supervised by General Probation Unit (n=117)

Cost

The feasibility of HOPE as an alternative to existing methods of community supervision, will depend in part on whether it adds to, or rather subtracts from, the total costs of operating the criminal justice and treatment system. We are not yet able to assign a final value to the cost savings under HOPE, but can speak to the direction of the change compared with probation as usual. Savings from prison days avoided dominate the HOPE savings and more than offset the increase in supervision and treatment expenditures associated with the program. For Adult Client Services (high risk, but lower risk than offenders in ICS) we estimated a savings in incarceration costs of $4,140 per offender assigned to HOPE. For Integrated Community Sanctions (the higher-risk probationers) we estimated a savings in incarceration costs of $6,157 per offender assigned to HOPE. These estimates are based on the conservative assumption that offenders sent to prison serve 50% of their term.

HOPE for All?

Our findings show that not all probationers succeed on HOPE. We found that a minority of probationers did not respond to the credible threat of sanctions and accumulated three or more violations. These probationers have identified themselves as either a. not amenable to supervision in the community or b. better suited to more regular judicial monitoring such as that provided by a drug court. As such, HOPE should be part of a continuum of supervision options available. There are currently 1,800 probationers under HOPE supervision in Honolulu. A total of 30 (approximately 2 percent) of these offenders have been transferred to the Honolulu Drug Court.

Implications of HOPE

Since most heavy illicit drug users move in and out of criminal-justice supervision, success in reducing their drug use via HOPE-style probation supervision could drastically shrink both the drug markets and the fiscal and human costs of drug law enforcement. There is no doubt that what has been achieved with HOPE in Hawaii is impressive. But it remains to be seen whether the HOPE effects will generalize to other jurisdictions. Programs such as HOPE require that judges, probation officers, police, corrections officials, and treatment providers cooperate towards a common goal. An important feature of the Hawaii experience was the role of the judge who created the program. Judge Steven Alm is a strong leader who motivated and coordinated the implementation of the program. If such leadership is lacking, the expected potential of a HOPE program may not be realized. A number of states are now considering implementing HOPE models and much will be learned as the number of jurisdictions and evaluations increase. Our evaluation in Hawaii leaves us cautiously optimistic but, as with any effective intervention, fidelity of implementation is critical. If the Hawaii findings hold in other jurisdictions, HOPE-like principles might make "community corrections" once again a credible alternative to incarceration, reducing the need to continue the trend of rising incarceration.

RECOMMENDATIONS

There are a number of ways the Federal government can help improve the state of offender management. A good place to start would be promoting small-scale experiments of alternative management approaches. Those that show promise can be scaled up, and those that don't show accompanying reductions in recidivism and incarceration can be cut. The Federal government can also help to improve the quality of the evidence base by devising standards for what can be counted as an evidence-based program. Below are a number of recommendations for how the Federal government can help improve the status quo.

Recommendation 1: Encourage HOPE Replication Studies on the Mainland

HOPE has demonstrated that even strongly drug-involved probationers can and will modify their behavior substantially in the face of high-probability sanctions. HOPE has been shown to significantly reduce incarceration overall by deterring drug use and other crimes. The challenge now lies in reorganizing the criminal justice system to deliver on credible threats. Delivering HOPE-style sanctions in a swift-and-certain manner requires cooperation and a willingness to change work practices. Whether this structural shift can be accomplished in other jurisdictions

remains an open question. Two replication studies are underway on the mainland but more are needed to determine whether Hawaii's HOPE experience is generalizable. Start-up grants, as provided for in the Schiff-Poe bill, could provide an important catalyst.

Recommendation 2: Support Experiments to Find the Essential Elements of HOPE

We don't yet know which elements of HOPE are necessary to bring about behavior change. If HOPE is shown to generalize to the mainland, a series of experiments will be needed to identify the essential elements of the program. The HOPE model relies on the credible threat of punishment. As punishment is (a) unpleasant for the person at whom it is directed and (b) expensive to mete out, an ideal strategy would deliver the smallest possible sanction necessary to bring about the desired behavior change. HOPE shows that even a few days in jail (if delivered swiftly and with certainty) is sufficient to motivate desistance from drug use for the large majority of offenders, and results in a large net reduction in incarceration for program participants. Whether non-incarcerating sanctions (delivered consistently) would be sufficiently motivating to lead to similar improvements in outcomes as observed under HOPE, while avoiding the harms of incarceration, is an important question open for empirical inquiry. Nor do we know whether extensions to the HOPE model would improve outcomes further (for example, adding GPS monitoring where appropriate, or using a program such as 24/7 for those with conditions to desist from alcohol use). The Federal government should support these types of experiments.

Recommendation 3: Experiment with HOPE-style Programs for <u>All Groups</u> of Offenders for Whom HOPE Represents a <u>Safe</u> Alternative to Incarceration

Hawaii's experiment with HOPE shows that a sizable percentage of those incarcerated might be successfully managed in the community: HOPE was able to dramatically improve the behavior of not only offenders with drug charges, but also of other offenders who were drug-involved while committing their offenses. People who keep stealing, or keep hurting others, are better suited to incarceration, but there are many other categories of offenders who are currently excluded from diversion programs and drug court programs that have the potential to do well under HOPE (HOPE's Domestic Violence Offender Program and Sex Offender Program have both shown impressive outcomes, though neither has been subjected to an experimental test). Taxpayers would benefit from extraordinary savings if we were able to identify the classes of offenders who are suited to HOPE supervision, and divert these offenders from jail or prison.

Recommendation 4: Continuum of Supervision Models

HOPE is a lower-cost alternative to other supervision strategies that have yielded similar outcomes. HOPE is not a drug court, although it shares many features of a drug court approach. Drug courts vary in how they manage their caseloads, in the ancillary services they offer, and in the testing and sanctions schedules they apply. What they all have in common is mandatory treatment and ongoing supervision from a judge, with offenders appearing before the judge for regularly scheduled updates. The drug court movement has been very successful. There are now over 2,000 such courts across the country (Huddleston, Marlowe & Casebolt, 2008). Although the number of drug courts has increased dramatically and now serve about 70,000 clients nationwide (Huddleston, Marlowe & Casebolt, 2008), there are many more candidate offenders

for drug court supervision than the number of available slots (California alone convicts over 70,000 offenders a year on non-violent drug charges). A key difference between HOPE and drug courts is the role of the judge. Under HOPE, probationers appear before a judge or hearings officer *only* if they have violated. This has important implications for caseloads and cost. Due to the intensive nature of the judge supervision in drug courts, there is a serious constraint on the caseloads these judges can manage. A court dedicated to HOPE could manage multiple thousands of probationers (the dedicated HOPE court in Honolulu currently oversees 1,800 probationers and is anticipated to oversee 3,000 HOPE probationers with *one* judge when operating at scale), compared to typical drug court caseloads of 50-100 probationers.

HOPE is innovative in economizing on treatment resources by not mandating formal treatment for every drug-involved offender. Rather, HOPE relies on regular random drug testing results and probationer requests for treatment referrals to indicate treatment need. This approach economizes on treatment resources as probationers who are able to remain drug free on their own are not required to enter a drug treatment program, allowing for more-intensive service provision for those who do need help. Probationers who fail on HOPE could then be transferred to a drug court program with closer judicial supervision. The HOPE court in Honolulu has transferred 30 probationers to their drug court. The cost savings of having HOPE courts work along-side drug courts to deliver a continuum of supervision would be substantial. HOPE would be the lower-cost front-end program, with drug courts (and the more resource-intensive ancillary services they offer) reserved for those who do not perform well under HOPE.

Recommendation 5: Encourage Strong Research Designs for Program Evaluations

The move towards evidence-based practices has one serious limitation: the quality of the evidence base. It is important to ask: What qualifies as "evidence" and who gets to produce it? Many programs are expanded and replicated on the basis of very weak evidence.[3] A recent study shows that the effect-size of offender programs is *negatively* related to study quality (the more rigorous the study is, the less likely it is to show an effect on recidivism). The "who" matters also. Several studies have found that evaluations authored by program developers report much larger effect sizes than those authored by independent researchers. Over half of the criminal justice programs designated as "evidence-based" programs on the National Registry of Evidence Based Programs, include the program developer as evaluator. The consequence is that we continue to spend large sums of money on ineffective programs (programs that do no good, and in certain circumstances actually do harm). It also means that many jurisdictions become complacent about searching for alternative programs that really do work.

We desperately need to start figuring out what does work in offender management. If we required that publicly funded offender programs be evaluated and show improved outcomes using strong research designs (experimental designs where feasible), we would likely halve the number of programs designated as "promising" or "evidence-based." Not only would this relieve taxpayers of the burden of supporting ineffective programs, it would also help researchers identify more promising directions for future intervention research.

---

[3] See Wright, Zhang, and Farabee (2010).

Recommendation 6: Encourage Independent Evaluations

Most state agencies contract with independent research organizations to evaluate programs that were developed and implemented by the agency. The evaluators then report evaluation findings directly to this agency. The agency is then directly involved in the design and implementation of the evaluation, and takes the lead in determining how (and if) these findings will be disseminated. Negative evaluation findings may meet agency resistance: reports may be delayed or suppressed, and the evaluator might face the risk of losing subsequent evaluation contracts. This arrangement is the equivalent of asking an employee to evaluate his own boss. It creates a quiet complicity between the agency and the evaluator, in that both now share the same goal of avoiding bad news and, if need be, protecting the source agency from criticism. It is not surprising that, nationwide, program evaluations conducted under state agency contracts have significantly higher effect sizes than the more objective research studies funded by federal agencies like the National Institutes of Health (Farabee, 2005). As a result, a large number of costly programs lumber along unchecked, and unimproved.

This conflict could easily be resolved by requiring all state agencies to submit their requests for evaluations to a truly neutral state agency such as (in California) the Bureau of State Audits (BSA), or another similar agency that has the expertise to work with the evaluated agencies and the eventually selected evaluator (Farabee, 2005). This coordinating agency would issue the requests for proposals, review the proposals, and select the contractor based on technical merit. The evaluator would report directly to this coordinating agency, which would distribute the findings. Creating distance between the agency and the evaluator would moderate the effect of any agency egos involved in demonstrating that whatever they are doing works, and neither they nor their staff would be able to pressure evaluators as they would not control the evaluation funds.

References

Farabee, D. (2005). *Rethinking rehabilitation: Why can't we reform our criminals?* Washington, DC: AEI Press.

Hawken, A (2010) "Behavioral Triage: A New Model for Identifying and Treating Substance-Abusing Offenders," *Journal of Drug Policy Analysis*: Vol. 3 : Iss. 1, Article 1.

Hawken, A. and Grunert, J. (2010) "Treatment for all means real treatment for few." *Offender Programs Report.* 13(6): 81-96.

Hawken, A., & Kleiman, M. (2009). Managing drug-involved probationers with swift and certain sanctions: Evaluating Hawaii's HOPE. Evaluation Report. NCJ 229023. National Institute of Justice. Washington.

Hawken, A., & Poe, A. (2008). Sanctions. In Evaluation of the Substance Abuse and Crime Prevention Act: 2007 Final report. California Department of Alcohol and Drug Programs. Sacramento.

Huddleston C.W., Marlowe D.B. & Casebolt R. (2008). Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States [Vol. II, No. 1]. Alexandria, VA: National Drug Court Institute.

Wright, B., Zhang, S.X., & Farabee, D. (In press). A squandered opportunity? A review of SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) for offenders. *Crime & Delinquency.*

Mr. KUCINICH. Thank you very much.
Mr. Roman.

STATEMENT OF JOHN K. ROMAN

Mr. ROMAN. Mr. Chairman, Thank you for the opportunity to speak today.

The U.S. criminal court system has two broad mechanisms to protect citizens from crime by drug-involved offenders. Offenders can be closely supervised and imprisoned, or public safety could be improved by employing more sophisticated interventions that both rehabilitate and deter.

For two decades, decisions have been made as if this was a zero sum game, a choice between protecting the public and helping offenders onto a better path. We have consistently chosen detection and punishment. But there is growing empirical evidence that this choice has led to more spending and more crime than would have been the case via a more balanced approach.

The challenge is to identify the right mix of intervention. To address this, I want to briefly discuss three issues today.

First, do those who enter drug court do better than if they were subject to more routine case processing? Despite dozens of studies, existing research has not yet definitively answered whether drug courts reduce crime and drug use.

To answer this question, in 2004 the Urban Institute, RTI International and the Center for Court Innovation received funding from the National Institute of Justice to conduct a rigorous, multi-site evaluation of adult drug courts. In this study, we interviewed over 5,000 offenders, conducted more than 1,000 drug tests and collected data on drug court clients in 23 drug courts in 8 States, and drug-involved offenders going through regular court processing in 4 of the 8 States. That was our comparison group.

We found that drug court participants self-report significantly less criminal behavior than the comparison group. During the 18-month tracking period, for instance, the total number of criminal acts was reduced by 52 percent. The reductions in offending persisted throughout the observation period, even after most in the treatment group had left drug court. We also found that significantly fewer drug court participants self-reported drug use in the comparison group.

Finally, we find that drug courts are cost-effective. The average net benefit to society is about $4,000 per drug court participant regardless of how well that participant did in drug court.

Second, given these results, we want to ask the question, why aren't more drug-involved offenders getting into drug courts? I estimate that some time this year, in 2010, after two decades of drug court operations, the one millionth drug-involved offender will enter a drug court. That achievement is cause for both applause and concern. While drug courts are now fixtures in most criminal courthouses, the rate at which offenders enroll is only growing very slowly. Each year, barely 3 percent of drug-involved offenders in need of treatment enter a drug court because of severe restrictions on eligibility.

Expansion of drug courts is also slowed by a lack of funds, limited treatment availability and concerns that drug court clients

treated in the community may commit new crimes that prison would have prevented. A 2008 Urban Institute study examined whether expanding drug court to more drug-involved offenders is cost beneficial. While we found that there are about 1½ million drug-involved arrestees entering the court system annually, we estimated only about 55,000 were treated in drug court. Again, that is less than 4 percent of all drug-involved arrestees and less than 1 percent of all arrestees.

We estimate that the United States spends slightly more than half a billion dollars a year to treat drug court clients. This investment yields more than a billion dollars in savings. So $2 in benefits for every $1 in cost.

We then tested what those costs would be if those offenders commonly excluded from drug court were allowed into drug court. We found in every category but one the benefits of adding these drug court clients exceeded the costs of treatment. Expanding drug court to all 1½ million drug-involved offenders would be expensive, with a price tag exceeding $13 billion annually. But the return would be more than $40 billion in benefits each year.

Third, given that drug courts are cost-effective but limited in their reach, how can the criminal justice system maximize their use without adding billions in new costs? One way would be to use less expensive strategies to identify defendants who can be encouraged to desist from offending, allowing drug courts to focus on those who cannot. For example, drug courts in a program like Hawaii's project HOPE could be linked to provide a continuum of more effective interventions for pre-trial defendants.

Adding a HOPE-like front-end diversion program would dramatically increase the criminal justice system's ability to manage drug-involved offenders in the community. This would be far less expensive than incarceration, would result in less crime and those who failed could go to drug court, which is in itself a cheaper, more effective option than prison. However, despite drug court success, without some dramatic expansion of effective supervision strategies, there is little reason to believe that the amount of crime committed by drug-involved offenders can be substantially reduced using current approaches.

Thank you, and I would be happy to answer your questions.

[The prepared statement of Mr. Roman follows:]

Testimony
of
John K. Roman

Justice Policy Center
Urban Institute

Domestic Policy Subcommittee
Oversight and Government Reform Committee
U.S. House of Representatives
Thursday, July 22, 2010

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to speak today about drug courts and pre-trial diversion. I am a senior researcher at the Justice Policy Center at the Urban Institute, where for more than a decade we have engaged in extensive research on the impact of drug courts and other pre-trial interventions on crime and public safety. However, the views expressed are my own and should not be attributed to the Justice Policy Center, the Urban Institute, its board, or its funders.

Drug Courts and Diversion

Drug use creates a substantial burden on both the American economy and America's social fabric, causing harms to users, their families, their communities, and all taxpayers who pay for law enforcement. In the past two decades, the use of alternatives to incarceration for drug-involved offenders has grown from experimental programs to business as usual, albeit at a modest level of investment compared with the costs of jails, prisons, and more traditional community supervision.

Typically, alternatives to incarceration programs require that drug-involved offenders remain in the community where they receive drug treatment under the supervision of a judge

or probation officer. As a result, the American criminal justice system stands at the nexus of drug use, drug treatment, and drug-related harm. The most visible point in that nexus is the drug court. In drug courts, drug-involved offenders repeatedly stand before the same judge to discuss their progress in drug treatment and to jointly plot a course that leads to their sober departure from criminal justice system supervision.

After two decades of operations, from 1989 to 2010, the drug court will see its one-millionth drug-involved offender this year. That achievement is cause for both applause and concern. Since drug courts average about a 10 to 20 percent reduction in recidivism among their clients, the cumulative effect of one million clients treated is surely associated with millions of prevented crimes, and tens of thousands of improved lives. The concern grows from the slow rate of adoption of this highly visible and efficacious program. While treatment alternatives to incarceration— and drug courts in particular— are becoming fixtures in criminal case processing, the rate at which offenders enroll in these programs is growing very slowly. Each year, less than 5 percent of drug-involved offenders in need of treatment actually enter a drug court. Some of the slowness in the expansion of drug courts results from severe restrictions on eligibility for participation, which prevents many arrestees who would do well in drug court from participating.[1] Those restrictions on eligibility result from both a lack of funds to serve everyone who could benefit from drug court and concerns that arrestees treated in the community rather than held in prison may commit new crimes while in drug court that prison would have prevented.

---

[1] Avinash Bhati and John Roman, "Treating Drug-Involved Offenders: Simulated Evidence on the Prospects of Going to Scale," *Journal of Experimental Criminology* 6, no. 1 (2010): 1–33.

At the same time, new diversion models, such as Hawaii's Opportunity Probation with Enforcement (HOPE),[2] have recently emerged. Early evidence suggests that diversion can reduce criminal recidivism at a much lower cost than drug court. The programs must be successfully replicated in various settings, and more research is required to understand the effects of these diversion programs on multiple participant outcomes. Still, there is enough encouraging data to begin to consider how these programs could be integrated into front-end court processing. In particular, would these programs crowd out current alternatives to incarceration, such as drug courts, or could they be integrated into an intervention continuum, with low-cost diversion at the front-end and higher-cost, intensive, treatment drug courts at the other end.

I discuss three issues in this testimony. First, I take up the issue of whether there is now sufficient evidence to conclude that drug courts are effective at reducing drug use and crime in light of soon-to-be released results from the National Institute of Justice–funded study, the Multi-Site Adult Drug Court Evaluation (MADCE). Second, I discuss why, in light of the improvement in drug court participant outcomes, drug courts are not used more often to divert drug-involved offenders from jail and prison. Finally, I discuss whether drug courts and other alternatives to incarceration programs are complements or substitutes, and consider what a continuum of diversion programming might look like and how it could substantially broaden the number of arrestees diverted rather than incarcerated.

Drug Courts, Drug Use, and Crime

[2] Mark Kleiman, *Making Community Supervision Work: Hope for Reducing Drug Abuse, Crime, and Incarceration* (Washington, DC: Washington Office on Latin America, 2010); Angela Hawken and Mark Kleiman, *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE* (Washington, DC: The National Institute of Justice, 2009).

Drug use affects crime in various ways. Extensive research links drug use to criminality.[3] Chronic drug users commit crimes to pay for their habit, individuals under the influence of drugs commit crimes because their inhibitions are lowered and their self-control is reduced,[4] and illegal drug markets create conflict and violence.[5] In addition, drug users are more likely to be the victims of violence than non-drug users, and criminal behavior increases as the frequency and intensity of use increase.[6]

However, crime decreases as drug use declines, particularly income-generating crimes. Research suggests that drug treatment can be effective in reducing demand for drugs among users, and consequently can reduce criminal offending related to drug use. Economic studies have found that drug treatment is more cost-effective than incarceration,[7] that intensive long-term treatment is most effective,[8] that direct interaction with a judge is more effective for serious drug users,[9] and that violent offenses cause the greatest economic damage to communities.[10] The Drug Abuse Treatment Outcomes Study (DATOS) found that after one year of treatment, drug use, illegal activities, and psychological distress were each reduced by about 50 percent. Arrest rates declined from 34 percent in the year before intake to 22

---

[3] R. J. MacCoun, B. Kilmer, and P. Reuter, "Research on Drug-Crime Linkages: The Next Generation," in *Toward a Drugs and Crime Research Agenda for the 21st Century* (National Institute of Justice Special Report, 2003); R. J. MacCoun, and P. Reuter, *Drug War Heresies: Learning from Other Vices, Times, and Places* (New York Cambridge University Press, 2001).
[4] P. Goldstein, "The Drug/Violence Nexus: A Tripartite Conceptual Framework," *Journal of Drug Issues* 14 (1985): 493–506.
[5] D. A. Boyum and M. A. Kleiman, "Substance-Abuse Policy from a Crime-Control Perspective," in *Crime: Public Policies for Crime Control*, edited by J. Q. Wilson and J. Petersilia (Oakland, CA: Institute for Contemporary Studies, 2002), 331–82.
[6] M. D. Anglin, D. Longshore, and S. Turner. "Treatment Alternatives to Street Crime: An Evaluation of Five Programs," *Criminal Justice & Behavior* 26, no. 2 (1999): 168–95.
[7] J. P. Caulkins, C. P. Rydell, W. L. Schwabe, and J. Chiesa, *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?* (Santa Monica, CA: Rand Corporation, 1997).
[8] D. D. Simpson, G. W. Joe, B. W. Fletcher, R. L. Hubbard, and M. D. Anglin, "A National Evaluation of Treatment Outcomes for Cocaine Dependence," *Archives of General Psychiatry* 56 (1999): 507–14.
[9] D. B. Marlowe, D. S. Festinger, and P. A. Lee, "The Judge Is a Key Component of Drug Court," *National Drug Court Institute Review* 4, no. 2 (2004): 1–34.
[10] Bhati and Roman, "Treating Drug-Involved Offenders," 2009.

percent one year after enrolling in treatment, and the average economic benefit from long-term residential treatment was $10,344.[11]

The criminal justice system stands at the intersection of drug, crime, and treatment. Drug users face a significant and ongoing risk of arrest and incarceration. For example, a part-time drug seller in Washington, D.C., has a 22 percent risk of imprisonment in any single year, and will spend about a third of a criminal career incarcerated.[12] Clearly, it is in the interest of the criminal justice system to distinguish between those who possess drugs for personal use or who commit crimes to support drug habits from those who commit drug-related crimes for profit and power. On one hand, treatment targeted at chronic drug users is effective. On the other hand, young drug users and sellers are most likely to be violent and thus most deserving of scarce prison beds.

However, it is difficult for the criminal justice system to distinguish drug users in need of treatment from criminal drug offenders, since drug sellers are often drug users.[13] The scale of the problem contributes to the difficulty as 1 in 100 Americans is in prison on any given day and 1 in 31 Americans is under criminal justice supervision (often for drug-related crimes).[14] The Bureau of Justice Statistics estimates that about half of both federal prisoners and jail inmates abuse or are dependent on drugs.[15] Few inmates ever receive treatment at any stage within the criminal justice system. This is because the criminal justice system has

---

[11] P. M. Flynn, P. L. Kristiansen, J. V. Porto, and R. L. Hubbard, "Costs and Benefits of Treatment for Cocaine Addiction in DATOS," *Drug and Alcohol Dependence* 57 (1999): 167–74.
[12] P. Reuter, R. MacCoun, and P. Murphy, *Money from Crime* (Santa Monica, CA: RAND Corporation, 1990).
[13] Reuter, MacCoun, and Murphy, *Money from Crime*, 1990.
[14] Pew Center on the States, *One in 31: The Long Reach of American Corrections* (Washington, DC: The Pew Charitable Trusts, 2009); Pew Center on the States, *One in 100: Behind Bars in America in 2008* (Washington, DC: The Pew Charitable Trusts, 2008).
[15] C. Mumola and J. Karberg, "Drug Use and Dependence, State and Federal Prisoners, 2004" (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2006).

trouble distinguishing users from offenders and because treatment slots are limited. [16] Among incarcerated populations, only about 15 percent received drug treatment.[17]

Drug-related crime is hard to combat, but for the past two decades, judges in the United States have used an approach radically different from the traditional adversarial process. Drug-involved offenders are screened at arrest, and those found to be eligible are assigned to special court dockets or caseloads where these arrestees receive community-based drug treatment under close judicial supervision. Those who fail drug court are usually incarcerated, while those who succeed return to their community with a new chance to be productive citizens.

Drug court processing begins soon after arrest. Drug court clients who meet clinical and legal eligibility requirements are offered the opportunity to enroll in drug court. Clinical eligibility criteria vary widely, but drug courts usually focus on a particular population. In some drug courts, that means that only those with long histories of substance abuse are eligible, while others may not focus on clients with demonstrated dependency, choosing instead to focus on a less serious population. Legal eligibility criteria are generally established at the beginning of court operations and many drug courts follow federal guidelines that exclude offenders with violent histories. Beyond violence, legal eligibility also varies widely along the continuum of criminal severity, with some courts focusing on first-time misdemeanants, others on clients with long histories of felony convictions, and most falling somewhere in between. Some of the decision about whom to target is a function of the availability of treatment resources and some is a function of the risk aversion of drug court stakeholders. While the drug court literature tends to show that the biggest benefits come

---

[16] A. Harrell and J. Roman, "Reducing Drug Use and Crime among Offenders: The Impact of Graduated Sanctions," *Journal of Drug Issues* 31, no. 1 (2001): 207–32.
[17] J. Karberg, and J. James, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002* (Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2005).

from serving the most serious offenders, the decision to treat serious offenders in the community rather than incarcerating them is politically risky. If the most serious offenders reduce their offending, and in doing so save victims and taxpayers money, they still are likely to commit more— and more serious— crime than would a less risky population.

Drug courts employ several techniques to ensure offenders complete their treatment as directed. Each drug court client is assigned a case manager to coordinate service delivery, including, but not limited to, drug treatment. Drug court clients are routinely drug-tested and regular court hearings review client behavior. If clients have committed infractions, graduated sanctions (sanctions that become incrementally more severe), including brief periods of confinement in jail, are used to encourage better future behavior. Persistent noncompliance can result in dismissal from the drug court, and dismissal often results in a prison sentence. In addition to sanctions, the level of treatment is reviewed on a regular basis, and positive behaviors are rewarded. The entire drug court process generally lasts 12 to 18 months, and a substantial period of drug-free and infraction-free behavior is required before a client "graduates" from drug court. Once a client graduates, his or her record is either cleared of the original charge or the sentence is substantially reduced.

How Effective Are Drug Courts?

Drug courts are among the most studied criminal justice interventions, with more than 100 studies having been completed to date. However, these studies have been widely criticized.[18] The central criticism is that they employ convenience samples or compare drug court clients with drug court failures, in effect stacking the deck to ensure that the study finds a positive effect of drug court. The consensus of prior research is that drug courts have a statistically

[18] See K. W. Whiteacre, "The Jury's Still Out on Drug Courts. Join Together Online" ([[Q: publisher?]], 2004). But also see, J. Roman, "Accreditation Key to Creating the Next Generation of Drug Courts" (Join Together Online, 2004).

significant, but relatively modest effect on client outcomes. Reviews of large numbers of drug court studies by the U.S. Government Accountability Office (2005), and meta-analyses by the Washington State Institute of Public Policy; Wilson, MacKenzie, and Mitchell[19]; and Shaffer[20] generally conclude that drug courts reduce the chance of rearrest by 10 to 20 percent in the year after enrollment. The research also suggests that drug court clients use fewer days of prison and tend to have longer crime-free periods before a new arrest. These meta-analytic studies collect data on all prior studies of drug courts that meet a minimum threshold of rigor and synthesize the findings into a single estimate of drug court effect. In the three meta-analytic studies, adjustments were made for the substantial variation in the quality of the studies included in the meta-analysis. While these adjustments do not rule out the possibility that poor study designs have contributed to the finding of drug court effectiveness, the consistency of these findings, and their similarity to results from the most rigorous randomized experimental studies, provide support for their conclusions.

Note that these findings do not apply to juveniles. Although there are now several hundred juvenile drug courts in the United States, much less is known about their effect.[21] In fact, there is ample reason to believe that drug courts will be substantially less effective for juveniles. First, the teen years are typically the peak of an individual's crime and drug-using career, and many— if not most— juvenile offenders will stop committing crimes and using drugs with no official intervention. Second, few juveniles meet clinical standards of addiction and thus the adult drug court model, which is centered on treating addiction, may be ineffective. Third, juveniles may experience worse long-term outcomes due to long-term

---

[19] D. B. Wilson, O. Mitchell, and D. L. MacKenzie, "A Systematic Review of Drug Court Effects on Recidivism," *Journal of Experimental Criminology* 2, no. 4 (2006): 459–87.
[20] Deborah K. Shaffer, "Reconsidering Drug Court Effectiveness: A Meta-analytic Review" (Dissertation, University of Cincinnati, 2006).
[21] Butts, Jeffrey A. and John K. Roman, editors. 2004. *Juvenile Drug Courts and Teen Substance Abuse.* Washington, D.C.: The Urban Institute Press.

exposure to the juvenile justice system and anti-social peers. And finally, juveniles with long-term juvenile justice system contact are likely to fare worse than similar peers who don't receive such intervention, as the labeling effect will be to brand them as addicts.

The Multi-Site Adult Drug Court Evaluation

Despite the breadth of research on drug courts and the general consensus of moderately positive effects, the poor quality of studies has led many to conclude that there is insufficient evidence to definitively state whether or not drug courts reduce crime and drug use. To address this concern, in 2004, the Urban Institute (UI), RTI International (RTI), and the Center for Court Innovation (CCI) received funding from the National Institute of Justice (NIJ) in the U.S. Department of Justice to conduct a rigorous, five-year, multi-site evaluation of adult drug courts. The objectives of the Multi-Site Adult Drug Court Evaluation (MADCE) are to

- Test whether drug court participants achieve better outcomes related to continued substance use and recidivism than similar offenders not exposed to drug courts;
- Isolate key individual and program factors that influence participant outcomes;
- Test effects of variations in drug court practices on participant outcomes;

To answer these and other questions, we conducted three waves of offender interviews, at baseline (entry into drug court for the treatment group or regular court for the comparison), 6 months, and 18 months, coupled with the collection of official rearrest data. The selected drug courts are located in seven geographic regions and represent a mix of urban, suburban, and rural locations. The comparison sites were drawn from the same clusters. Some comparison sites do not require any court-directed treatment; some mandate treatment but without the added supervision components found in drug courts; and some even monitor the offenders through drug testing or case management. We believe that our design creates a better study than comparing drug court participants strictly to a "no-

treatment" comparison group since offenders often receive treatment, whether through probation, diversion programs, or other mechanisms. Therefore, the question is whether the drug court model adds value through its structured combination of treatment with case management, drug testing, judicial status hearings, sanctions, incentives, threat of incarceration for failing, and other components.

MADCE Results

We found that drug court participants self-report significantly less criminal behavior than the comparison group. Over the full 18-month tracking period, the sampled drug courts reduced the probability of any reoffending by 23 percent relative to the comparison group (from 64 to 49 percent); and reduced the total number of criminal acts by 52 percent (from 110 to 52). These reductions in offending persist throughout the 18 months of observation, even after most in the treatment group have left drug court. The largest impacts were on drug-related crime, including both drug possession and sales offenses. Drug courts also significantly reduced DWI and property-related crime. Significant effects were not apparent, however, on violent, weapons-related, or public order offenses, all of which were rare in both samples. We also found that drug court participation led to an apparent reduction in rearrests, although these results were not statistically significant. The 24-month rearrest rate dropped from 62 to 52 percent, and the total number of rearrests over that same period dropped from an average 1.66 to 1.25.

We find that reductions in drug use are the best predictor of reductions in crime. At six months, significantly fewer drug court participants (40 percent) self-reported drug use than in the comparison group (55 percent). Drug court participants averaged significantly fewer days of drug use per month, fewer days of serious drug use per month, and were significantly less likely to report marijuana or alcohol use. All of these improved outcomes for drug court

participants remained at 18 months, although the rate of drug use increased for both groups— for instance, 56 percent of drug court participants self-report drug use at 18 months, compared with 76 percent in the comparison group.

Overall, we found some evidence that adult drug courts improved socioeconomic and family conflict-related outcomes. Across 28 socioeconomic measures, including employment status, school status, and annual income, 23 measures showed better results for drug court participants. However, the effect sizes were modest, and only three total differences were statistically significant. We also found that drug court participation led to less family conflict and greater emotional support from family members, but these effects also were modest. Finally, there was little evidence that adult drug courts led to improved mental or physical health or to a lesser risk of homelessness, particularly at the final 18-month mark.

Finally, drug courts appear to be cost-effective. The average net benefit to society is about $4,000 per drug court participant, regardless of how well that participant did, although the difference is not statistically significant. Consistent with prior studies, the biggest benefits come from reductions in crime, where crime victims experience fewer costs from crime committed by drug court participants than crimes committed by the comparison group. Among public agencies, drug court participants used significantly less prison and police resources. Drug court participants did use more of some public resources, including significantly more court and drug court resources, more community supervision, halfway houses, homeless shelters, public housing, and government support.

Why Don't More People Go through Drug Court?

Beginning with a few experimental programs developed as a grassroots initiative in the late 1980s, the drug court concept quickly grew into a full-scale movement in the United States. Fueled in part by the injection of federal funding, but also by anecdotal evidence of

success, drug courts rapidly expanded. A survey by the Urban Institute in 2005 found more than 700 adult drug courts in active operation. The typical adult drug court is small, with an average of 40 to 80 clients. While most medium to large American counties had a drug court by the early part of this decade, the recent growth in drug courts has mainly been from the implementation of drug courts in small rural or tribal communities, rather than from expansion of existing courts. Thus, while the number of drug courts is increasing, the number of clients served by drug courts is increasing at a much slower rate.

Despite the growing consensus that drug treatment for drug-involved offenders is effective in reducing offending, strict drug court eligibility rules have limited the impact of drug courts on public safety. Only a small fraction, 5 percent or less, of drug-involved arrestees enter a drug court each year. Thus, positive drug court experiences can achieve only small reductions in crime. If, in the best-case scenario, drug courts average a 20 percent reduction in reoffending and, again in the best case, 5 percent of drug-involved offenders enter a drug court, the result is a 1 percent reduction in the crime rate for drug-involved offenders. Even though the cumulative effect of drug courts over time may be greater, due to the substantial constraints on eligibility, the overall impact can only be small.

The limited access to treatment for criminal offenders appears to be based on subjective judgments of the risks of treating offenders in the community and the benefits of treatment. The strict eligibility rules suggest that risks are assumed to be high for most offenders, and the benefits of treatment are assumed to be low. As a result, almost all drug-involved arrestees are determined to be ineligible for participation in community-based treatment programs. An important question for the nation's drug policymakers is whether a substantial expansion of substance abuse treatment would yield benefits from reduced crime and improved public safety. A related question is whether evidence-based strategies can be

developed to prioritize participation, given limited resources, perhaps through a continuum of diversion programs, beginning with the least costly and least intensive interventions, before moving to a drug court.

A 2008 study by the Urban Institute was aimed at providing policymakers some guidance on whether expanding this model to more drug-involved offenders is cost-beneficial. The study linked data from the National Survey on Drug Use and Health (NSDUH) and the Arrestee Drug Abuse Monitoring (ADAM) to develop estimates of the prevalence of various profiles that reflected categories of attributes that led arrestees to be eligible or ineligible for drug court participation. Data from the Drug Abuse Treatment Outcome Study (DATOS) were used to compute expected crime-reduction benefits of treating clients with particular profiles. The resulting dataset— including more than 40,000 distinct profiles— permitted the benefit-cost analysis of a limited number of simulated policy options.

Data on adult drug court eligibility rules were gathered from a survey of 600 drug courts in 2005 administered as part of MADCE. Across all adult drug courts, dozens of different eligibility restrictions can be found. Some of those eligibility rules are subjective,[22] and others are not routinely recorded in administrative data. Thus, not all exclusion rules could be modeled in our data. However, we were able to identify six attributes (number of prior arrests, past violence, past treatment, age, gender, and alcohol abuse) that are used most oftento determine eligibility. Those with a current violent charge were excluded in 88 percent of drug courts, and those with past violence were excluded in 63 percent of drug courts. Those with another active case were excluded in 50 percent of drug courts. Those with prior

[22] One common place where individuals are excluded from drug court is after an interview with the intake official (who may be drug court staff, a probation officer, or someone from the prosecutor's office). Intake officials may exclude people whom they feel are too high-risk to be in the community based on a sense from the interview that the person would not succeed in drug court.

treatment failures were excluded by 49 percent of drug courts. Those who had an alcohol problem along with a drug problem were excluded by 34 percent of drug courts. Since individuals are excluded on the basis of any single rule violation, it is easy to see how so many individuals are excluded from drug court.

We found that there are annually about 1.5 million drug-involved arrestees who are probably guilty (which is the population generally targeted by drug courts). Under current rules that limit access to treatment for most of this population, there are about 55,000 individuals treated annually— about 32,000 are drug dependent and 23,500 at risk of drug abuse. This group that received treatment represents less than 4 percent of all drug-involved arrestees and less than 1 percent of all arrestees.

In total, a little more than $500 million is spent annually to treat those drug court clients. Assuming only average reductions in offending from drug treatment (following the results of the DATOS study) and no additional benefit from drug courts, this investment yields more than $1 billion in annual savings. The primary beneficiary of these savings is the public, which benefits from having fewer citizens victimized in their communities. Overall, the current adult drug court treatment regime produces about $2.21 in benefits for every $1 in costs, for a net benefit to society of more than $600 million. Note that if only the benefits to the government (from reductions in law enforcement, court, and corrections expenses) are considered, then the benefits may not exceed the costs. If, however, the purpose of law enforcement is to protect and serve, then benefits to private citizens must be considered.

Next, we tested whether loosening drug court eligibility rules and allowing larger numbers of drug-involved offenders to enter drug court would be cost-beneficial. In the first step, we tested whether expanding drug court to everyone currently eligible would be cost-effective. We estimate that there are about twice as many arrestees currently eligible for drug

court (109,000) than there are available drug court treatment slots (55,365). If all 109,000 were treated, the costs of treating these additional clients would total about $1 billion. The additional 54,000 people treated would have slightly worse outcomes than the current drug court population. The net result is a modest decrease in the benefit-cost ratio to 2.14 from 2.21. But the benefits were still positive and this expansion of treatment yields a benefit to society of more than $1.17 billion.

We then tested several other expansions of drug courts by eliminating current eligibility rules. Every policy change, save one,[23] simulated in this study yielded a cost-effective expansion of drug treatment. That is, removing current program eligibility restrictions would continue to produce public safety benefits that exceed associated costs. Many drug courts exclude individuals with a pending case in another court. We estimate that expanding treatment access to those with a pending case is cost beneficial, with about $1.65 billion in total benefits. We find that allowing those with past violence into court-supervised treatment is as cost-beneficial as current practice, with a benefit-to-cost ratio of 2.15. Expanding drug courts to include individuals with a history of failed treatment is also cost-beneficial.

Most strikingly, removing all eligibility restrictions and allowing access to treatment for all 1.47 million at-risk arrestees would be most cost-effective. Treating all at-risk arrestees would cost more than $13.7 billion and return benefits of about $46 billion, a benefit of $3.36 for every dollar spent. At the same time the drug court debate is occurring, a new model is emerging that offers a very different approach to helping offenders stay off drugs?.

Creating a Continuum of Interventions

[23] Many drug courts exclude individuals that have both an alcohol and a drug problem. Those with less serious drug problems return a slightly positive return on society's investment in treatment. Treating those with alcohol problems and more serious drug problems is not cost-effective (0.70:1).

Hawaii's Opportunity Probation with Enforcement (HOPE) focuses on the certainty in detecting and punishing drug use in a probation population. The strategy is to focus the resources of probation on catching every violation of probation (specifically continued drug use) and to punish every infraction. An evaluation shows that "80 percent of the criminal justice population can and will desist without a treatment mandate," and that HOPE leads to substantial reductions in drug use and new offending.[24] Thus, HOPE is a "mandated desistance" program that is quite distinct from the "treatment-mandate" model of drug court. The focus is on desistance, not treatment.

The results from HOPE are impressive enough that many policymakers and other stakeholders are interested in applying the model. Given the substantial past investment in drug courts and the dramatic results from the HOPE demonstration, it is fair to ask how and if drug courts and HOPE can coexist. In describing the HOPE model, Kleiman notes that a "mandated-desistance program could also serve as the 'front end' of a treatment-mandate program."[25] That is, HOPE could serve as a front-end gatekeeper into the criminal justice system, with drug courts serving as final step before prison. If large numbers of drug-involved offenders can refrain from offending due to the threat of sanctions, those who remain could enter drug court for more intensive— and expensive— treatment. Such a system would hardly shutter drug courts. In fact, a five-fold increase in the number of adult drug courts would likely be required to serve everyone who fails HOPE.

This idea is logical and follows a path being explored to reform the juvenile justice system. The reform model "Reclaiming Futures" was developed by the Robert Wood Johnson Foundation and is being tested by the Office of Juvenile Justice and Delinquency in the U.S. Department of Justice. The Reclaiming Futures idea is to triage boys and girls

[24] Hawken and Kleiman, *Managing Drug Involved Probationers*, 2009.
[25] Kleiman, *Making Community Supervision Work*, 2010, 4.

entering the juvenile justice system to identify those with substance disorders. Youth are screened, and those with symptoms of more serious problems are sent for a full diagnostic evaluation. If the diagnosis is that the youth is at risk of substance dependence, the youth is then sent for progressively more intensive treatment, with juvenile drug courts eventually occupying the deepest end of the continuum. A similar model could be developed in the adult criminal justice system, with a HOPE-like program being employed early in case processing and drug court occurring later for those with more serious problems or problems more resistant to intervention.

It is too early in the development of the HOPE model to comment extensively about how drug courts and HOPE can be linked together. The HOPE project was evaluated under close-to-ideal conditions and has not yet been replicated in large numbers of other places and times. Until effectiveness studies are performed in other real-world situations, the strengths and weaknesses of HOPE are difficult to evaluate, and, thus, proposals for a continuum linking drug court and HOPE are probably premature.

However, it is possible to consider the strengths and limitations of the drug court model and to consider how those strengths and weaknesses relate to HOPE. If HOPE and drug courts are complementary, the two models will not require different resources and will either solve different problems for the same drug-involved offenders or focus on different client bases. That is, if the two models are to coexist, HOPE must fill in the holes in the drug court model, and vice versa, without requiring the same people, places, and funds that drug courts require to be successful. Too much overlap and the models become substitutes. Drug courts are a substantial advance over traditional strategies for dealing with drug-involved offenders and reverse a long-term trend toward the commoditization of offenders. In 1974, a literature review of all existing research on the effectiveness of drug treatment famously

concluded that "nothing works in drug treatment." This finding from "The Martinson Report" led to two decades during which the criminal justice system was resistant to the use of drug treatment to reduce criminal offending. During that period, crime rates increased, and mass incarceration of drug-involved offenders led to overcrowded prisons that were ineffective in rehabilitating drug offenders. The creation of drug courts not only defied that trend, but inspired court systems to reconsider the idea that assembly-line processing of cases was an efficient means of improving public safety. Non-adversarial case processing has shown potential to improve life-course outcomes not only of drug-involved offenders but other individuals with antisocial behaviors. The reforms brought to the court system by drug courts can be adapted to reform other criminal justice operations, most notably probation and parole.

Thus, the development of HOPE represents a natural extension of the problem-solving court evolution that has been occurring since drug courts were introduced. HOPE continues the use of the courts' coercive power to help individuals help themselves desist from crime and drugs. For many individuals, HOPE will represent a better social investment. That is, if individuals can desist without the public paying for the costs of treatment, then substantial benefits to the public should result.

There are two important concerns about integrating HOPE and drug courts into a single model, as points along a continuum of interventions. First, such a model does not address any of the criticisms that have been leveled against drug courts. The drug court judge will still be engaging in social work-like activities for which the judge may not have sufficient training.[26] The drug court defendant will still have to forgo some procedural rights.[27] And,

[26] M. B. Hoffman, "The Rehabilitative Ideal and the Drug Court Reality," *Federal Sentencing Reporter* 14 (2002): 172–78.

the criticism will remain that each drug court is unique enough that policymakers have difficulty determining whether any particular drug court is effective.

Second, integration of the two approaches in a single model similarly does not address the three major concerns about the HOPE model. One concern about HOPE is that drug-involved offenders desist during their period of supervision but do not attain the skills they would gain in drug treatment that allow them to continue to desist. A credible case can be made that those who return to drug use after their supervision ends would have been better served by participating in drug court. A second concern is that those who ultimately fail in HOPE will have substantially delayed their entry into treatment, which will likely reduce the likelihood of positive outcomes. Further research should explore whether strategies can be developed to address these issues.

A more important concern is that in theory HOPE reverses the trend away from criminalizing drug dependence, which should be addressed as a public health issue rather than a criminal issue. The advent of drug courts and other problem-solving courts was seen by many as a movement by the courts toward a more rehabilitative model. Certainly one central tenet of the drug court model is that relapse is part of recovery and that the traditional criminal justice response of incapacitation is only warranted some of the time. Another central tenet is that whenever possible, treatment is preferred to incapacitation. The HOPE model moves back toward traditional practice, albeit within a more progressive contingency management framework.

Overall, though, there is little reason to believe that a HOPE-like model and drug courts cannot coexist. And, there is a substantial advantage to incorporating them into a single intervention continuum. That is, real barriers remain to broader expansion of drug courts.

---

[27] National Association of Criminal Defense Lawyers, "America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform" (Washington, DC: NACDL, 2009).

While risk tolerance ultimately determines who gets into a drug court, funding determines how many people get into drug courts. At the moment, there is little reason to believe that substantial increases in drug court funding are imminent.

At the federal level, Congress has committed to funding some expansion of drug courts to new populations or new communities but has strongly resisted funding the expansion of drug courts in underserved jurisdictions. Thus, growth will be modest. For example, the FY 2010 House budget contains funding for 100 new drug courts (adding 5,200 new clients) and funding to serve 870 children of methamphetamine addicts. While this represents a substantial increase in drug court coverage, it nevertheless is dwarfed by the more than 1.4 million drug-involved arrestees at risk of drug abuse and dependence who enter the American criminal justice system each year but are not served by a drug court.

Conclusion

The challenge for communities that seek to embrace the drug court model is to identify sustainable funding while operating in a system that does not reward those who care more about long-term outcomes than short-term costs. Most drug court funding comes from the court system and treatment providers, but these agencies do not reap the benefits of drug court. Corrections and community supervision agencies reap some reward from drug courts by not having to supervise successful participants, but they do not shoulder any of the drug court costs. The main beneficiaries of drug courts are private citizens who would have been victims but for the drug-involved offenders' desistance from crime. However, since the identities of victims who were not victimized cannot be determined, these benefits are invisible to individuals and society. Thus, a substantial challenge to the growth of drug courts and the adaptation of drug court principles is that the costs are large and visible while the benefits are diffuse.

Given this disconnect between who pays for drug courts and who benefits, it is relatively easy to forecast the future for drug courts. Looking ahead a decade, it seems reasonable to predict that drug courts will have a similar reach as they do today. And, it seems reasonable to believe that drug court practice will not have advanced a great deal either, as drug court operations have not changed much in the past decade. That does not mean that drug courts will not continue to make positive contributions in terms of enhanced public safety and improved lives for clients, their families, and their communities. Rather, it means that the full potential of this approach to reform the American criminal justice system will remain untapped.

If HOPE is successfully replicated, adding a HOPE-like front-end diversion program would dramatically increase the ability of the criminal justice system to effectively manage drug-involved offenders in the community. Managing this population in the community is far less expensive than incarceration. More effective management means less new criminal victimization. Despite the success of drug courts, without some dramatic expansion of effective supervision strategies, there is little reason to believe that the amount of crime committed by drug-involved offenders can be reduced.

Mr. KUCINICH. Mr. Marlowe.

STATEMENT OF DOUGLAS B. MARLOWE

Mr. MARLOWE. Good afternoon, Mr. Chairman, other members of this distinguished committee.

As Chief of Science and Policy for the National Association of Drug Court Professionals, it should not be surprising to you that I will begin my testimony by arguing that drug courts work and presenting the evidence. What might surprise you is that I will argue that drug courts do not work for everybody. They should not be applied to everybody in the criminal justice system. We do need a continuum of interventions that include multiple evidence-based programs, to include Proposition 36, to include Project HOPE in Hawaii and other interventions.

First, the clear message about drug courts. Drug courts work. In fact, there are people in this room right now taking medications for cancer, heart disease, asthma that have less proof of efficacy than drug courts. The highest level of scientific proof comes from what are called meta-analyses. These are when scientists that are not part of the drug court field review all of the studies that have been done on drug courts, select out only the ones that are scientifically rigorous, and then average the effects of the intervention across all of those studies.

The placards at the front of the room show the results of five meta-analyses conducted by independent organizations, all concluding that drug courts reduce crime by an average of approximately 10 to 15 percent better than the alternative. But that masks a lot of variability. The best drug courts cut crime rates in half, which is unbelievable. The worst drug courts increase crime rates, sometimes by as much as 15 to 20 percent.

The important question is, what separates the good drug courts from the bad drug courts? And the answer is two-fold. The first is, the good drug courts treat the hardest offenders. They do not pick offenders who could be handled in Proposition 36. They do not treat offenders who would respond to Project HOPE. We take the ones who are seriously addicted, or should take the ones who are seriously addicted, the ones who other programs can't handle, the ones who drop in and out of treatment, who fail repeatedly on probation and who keep committing crimes.

The drug courts that treat those offenders get large effects. The drug courts that treat the easier offenders get small effects. Why? Because they are no better than the alternative. Easy offenders get better in any program. So drug courts are not worth the extra expense for those individuals.

Second, when drug courts are treating the appropriate target population, the effective drug courts hold the line. They do not skimp on treatment. They do not cut back on supervision. And God no, they do not give offenders multiple chances to act out without being held accountable for their actions.

But what about the other offenders who can do well in other programs? What about the offenders who are not in fact addicted to drugs or alcohol? More than half of drug offenders are not clinically addicted, and therefore treatment services are not appropriately indicated to that population. Programs such as project HOPE bring

behavioral principles to bear that have not been brought to bear in standard probation practice. It is about time, and that program should be extended throughout the country at the State, national, local level, with the appropriate evidence guiding its implementation and evaluation.

For individuals who are addicted to drugs or alcohol, who have real drug problems but are not antisocial, who would be willing and able to go to treatment on their own, they don't need drug courts. They can and did respond well to Proposition 36. Proposition 36 was effective with about 25 percent of the population. That 25 percent were exactly where they needed to be. It was the other 75 percent who were not.

Which brings us to Congress' role. First, there are many drug courts still treating non-addicted low-risk offenders. The Drug Court Discretionary Grant Program and other Federal funding needs to require drug courts as a condition of Federal funding to treat their appropriate target population of high-risk offenders, including violent offenders. We can talk about that during the questions.

Second, drug courts are treating about 5 to 10 percent of the eligible population. It is time to fund drug courts at the level that was originally intended in the crime control bill in the 1990's, which was $250 million a year, which is a drop in the bucket compared to what we pay for incarceration and other correctional costs in this country.

Third, we need evidence-based sentencing. It is not fair to hold the people in this room accountable for poisoning our stream when the poison is entering the water five miles uphill. The problem with individuals being put into the criminal justice system is at the point of law enforcement contacts, prosecution charging practices and excessive punishment. That brings in evidence-based sentencing, and that is what we need.

Thank you very much, and I am happy to answer questions when the time comes.

[The prepared statement of Mr. Marlowe follows:]

U.S. House of Representatives
Committee on Oversight and Government Reform

Subcommittee on Domestic Policy

Hearing on

Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders

July 22, 2010

Testimony of
Douglas B. Marlowe, J.D., Ph.D.
Chief of Science, Law & Policy
National Association of Drug Court Professionals

Chairman Kucinich, Ranking Member Jordan, and distinguished Members of the Subcommittee, I am honored to have the opportunity to appear before this Subcommittee on the critically important matter of front-end alternatives to incarceration for drug-involved offenders. This Subcommittee is already well aware of what is at stake, so I will not dwell on the striking national statistics. Suffice it to say that more than 1 out of every 100 adult American citizens is now behind bars, with the burden borne disproportionately by racial and ethnic minority citizens and the poor (Pew Center on the States, 2008). Our prisons are overcrowded with nonviolent offenders charged with drug-related offenses, and our budgets are buckling under the weight of enormous correctional expenditures; yet, crime rates and drug-use initiation rates are barely budging or are merely shifting in character.

As requested by the Subcommittee, I will focus my comments on the following key issues:

- the extent to which drug courts are cost-effective in reducing recidivism, drug use, and improving other outcomes; and
- the advisability of and practical obstacles to altering current eligibility restrictions for drug courts.

As was also requested, I will secondarily address the following issues:

- lessons learned from state-level initiatives such as Proposition 36 in California;
- evidence for the effectiveness of coerced abstinence programs, such as H.O.P.E. (Hawaii Opportunity Probation with Enforcement); and
- how different types of illegal drug using populations respond to and benefit from formal clinical assessment, a court-ordered treatment plan, and sanctions and monitoring.

My position is straightforward: The sciences of corrections and substance abuse treatment have advanced considerably in recent decades. We know a lot more now than we did in the 1970s, 1980s and even 1990s. We understand the basic parameters for intervening effectively with drug-involved offenders in community-based settings. We know how to supervise drug offenders closely; reliably detect drug use; apply gradually escalating sanctions for infractions and incentives for achievements; and treat the underlying disease of addiction, where it is present.

Unfortunately, our laws and policies have not kept pace with this knowledge. They are still based on outdated sentiments from decades past, when we did not appreciate the neurobiology of addiction; when we did not have validated risk-and-needs assessment instruments that could predict recidivism and match drug-involved offenders to the most suitable programs; and when we did not know how to develop effective treatment and supervision care plans that could maintain drug offenders safely in our communities.

I will argue that, based upon a substantial body of research evidence, we now know several important and reliable facts:

- Drug courts reduce crime, reduce drug abuse, improve family relationships, and save considerable money for taxpayers.
- Drug courts are best suited to a specific sub-population of offenders who are (a) compulsively addicted to drugs and/or alcohol, and (b) at high-risk for failure in less stringently supervised programs.
- Adherence to the "10 Key Components" (NADCP, 1997) of drug courts is necessary for success with this high-risk, addicted population; therefore, watering down the model for these offenders is contraindicated.
- Other types of drug-involved offenders, of which there are *many*, can be safely and effectively supervised using other evidence-based models, including H.O.P.E. and Proposition 36. The challenge is to develop a full continuum of evidence-based programs for a given jurisdiction, and match drug-involved offenders to the most effective and cost-efficient interventions given their clinical needs and prognosis for success.
- Validated risk-and-needs assessment tools exist, or can be readily developed, to assist in the process of matching drug-involved offenders to the most effective and efficient dispositions.

Several concrete policy recommendations stem directly from these science-based observations:

1. Drug court eligibility criteria in many states or localities may be unduly restrictive and do not incorporate the lessons of research. Congress can play an important role by directing Federal grants toward drug courts that target more serious offenders, and by removing the categorical violence exclusion from the Crime Control Act.
2. Drug courts are treating, at best, 5 to 10 percent of the population in need of their services. It is time to fill this service-gap by directing the large population of drug-addicted offenders who can be managed safely in the community away from costly and ineffective incarceration and toward evidence-based drug court programs.
3. Criminal sentences in many states are based predominantly on offense-based factors, to the near exclusion of offender-level characteristics, such as risks and needs. Congress should encourage the incorporation of validated risk-and-needs assessment information into sentencing decisions. Under the rubric of what is now being called *evidence-based sentencing*, courts should be permitted or required to include data on effectiveness and cost-effectiveness in their calculus of decision-making when rendering criminal dispositions. The U.S. Sentencing Guidelines should be amended in this regard, and the states should be encouraged through grants from DOJ and other agencies to revise their sentencing policies to incorporate evidence-based practices into sentencing determinations.

EFFECTIVENESS OF DRUG COURTS

Criminal Recidivism

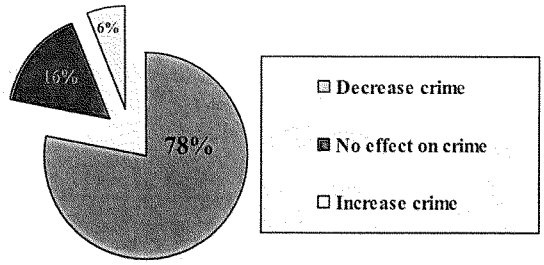
More research has been published on the effects of adult drug courts than virtually all other criminal justice programs combined. By 2006, the scientific community had concluded from advanced statistical procedures called *meta-analyses*[1] that drug courts reduce criminal recidivism, typically measured by lower re-arrest rates for new offenses and technical violations. The Table below summarizes the results of *five* meta-analyses performed by independent research organizations unconnected with the drug court field. In each analysis, the results revealed superior effects for drug courts over randomized or matched comparison samples of drug offenders who were on probation or undergoing traditional criminal justice case processing.

On average, the drug courts were found to have significantly reduced crime rates by an average of approximately 8 to 26 percent more than the comparison conditions. The "average of the averages" across all five meta-analyses represents approximately a 10 to 15 percent greater reduction in criminal recidivism for drug courts over the alternatives.

Citation	Institution	Number of Drug Courts	Crime Reduced on Avg. by . . .
Wilson et al. (2006)	Campbell Collaborative	55	14% to 26%
Latimer et al. (2006)	Canada Dept. of Justice	66	14%
Shaffer (2006)	University of Nevada	76	9%
Lowenkamp et al. (2005)	University of Cincinnati	22	8%
Aos et al. (2006)	Washington State Inst. for Public Policy	57	8%

Because these figures are *averages*, they mask substantial variability in the performance of individual drug courts. As can be seen from the following pie chart, more than three quarters of the drug courts (78%) were found to have significantly reduced crime (Shaffer, 2006), **with the best drug courts reducing crime by as much as 35 to 45 percent** (Lowenkamp et al., 2005; Shaffer, 2006; Carey et al., 2008).

[1] Meta-analysis is an advanced statistical procedure that yields the most conservative and rigorous estimate of the average effects of an intervention. Independent researchers systematically review the research literature, select out only those studies that are scientifically acceptable according to standardized criteria, and then statistically average the effects of the intervention across all of those good-quality studies (e.g., Lipsey & Wilson, 2002). The result provides the best probability estimate of how the intervention is likely to work under typical real-world conditions.



These results were anything but fleeting. In well-controlled, experimental studies, the **reductions in recidivism were determined to have lasted at least 3 years post-entry** (Gottfredson et al., 2005, 2006; Turner et al., 1999) **and in one study the effects lasted an astounding 14 years** (Finigan et al., 2007). Researchers are still following the participants in some of those studies to determine how long the effects of the drug courts might persist.

On the other hand, as can also be seen from the pie chart, a substantial minority of the drug courts (16%) was found to have had no impact on crime, and a small number (6%) were actually associated with higher re-arrest rates. It is here that the most critically important information may be gleaned from two decades of practical experience. Researchers have devoted considerable energy and resources to pinpointing what it is, exactly, that distinguishes effective drug courts from ineffective or harmful ones. The lessons learned from this research have provided critical guidance to the field for designing effective, safe and cost-effective programs for drug-involved offenders, and crafting rational evidence-based drug policies for the U.S. These best-practice findings and their policy implications are discussed in greater detail below in the testimony that follows. First, however, as requested by the Subcommittee, I will review the research on the effects of drug courts on outcomes other than criminal recidivism, as well as their cost-effectiveness and return-on-investment for U.S. taxpayers.

Other Outcomes

In 2005, the U.S. Government Accountability Office (GAO, 2005) concluded that drug courts reduce crime; however, relatively little information was available at that time about their effects on other important outcomes, such as substance abuse, employment, family functioning and mental health. In response to the GAO Report, the National Institute of Justice (NIJ) sponsored a national study of adult drug courts, entitled the *Multisite Adult Drug Court Evaluation* (or *MADCE*). The *MADCE* compared outcomes for participants in 23 adult drug courts located in seven geographic clusters around the country (n = 1,156) to those of a matched comparison sample of drug offenders drawn from six non-drug court sites in four geographic clusters (n = 625). The participants in both groups were interviewed at entry and

at 6 and 18-month follow-ups, provided oral fluid specimens at the 18-month follow-up, and their official criminal records are being examined for up to 24 months.

The 6 and 18-month findings were recently reported at the 2009 Annual Conference of the American Society of Criminology (Rempel & Green, 2009; Rossman et al., 2009). In addition to significantly less involvement in criminal activity, the drug court participants also reported significantly less use of illegal drugs and heavy use of alcohol[2]. These self-report findings were confirmed by saliva drug tests, which revealed significantly fewer positive results for the drug court participants at the 18-month assessment (29% vs. 46%, $p < .01$).

The drug court participants also reported significantly better improvements in their family relationships, reduced family conflicts (which might translate into reduced incidences of child abuse, child neglect and domestic violence), and trends favoring higher employment rates and higher incomes. These findings now confirm that drug courts elicit substantial improvements in other outcomes apart from merely criminal recidivism.

Cost-Benefits

In line with their positive effects on crime reduction, drug courts have also proven highly cost-beneficial (Belenko et al., 2005). A recent cost-related meta-analysis performed by The Urban Institute concluded that drug courts produce an average of $2.21 in direct benefits to the criminal justice system for every $1 invested — a 221% return on investment (Bhati et al., 2008). When drug courts target their services to the more serious, higher-risk offenders, the average return on investment was projected to be even higher: $3.36 for every $1 invested.

These savings reflect provable, measurable cost-offsets to the criminal justice system stemming from reduced re-arrests, law enforcement contacts, court hearings, and jail or prison beds. When other indirect cost-offsets to the community were also taken into account — such as savings from reduced foster care placements and healthcare service utilization — studies have reported economic benefits ranging from approximately $2 to $27 for every $1 invested (Carey et al., 2006; Loman, 2004; Finigan et al., 2007; Barnoski & Aos, 2003). The result has been **net economic benefits to local communities ranging from approximately $3,000 to $13,000 per drug court participant** (Aos et al., 2006; Carey et al., 2006; Finigan et al., 2007; Loman, 2004; Barnoski & Aos, 2003; Logan et al., 2004).

BEST PRACTICES IN DRUG COURTS

As stated previously, some drug courts are decidedly more impactful and cost-efficient than others. Research is now providing clear guidance about the specific characteristics that distinguish effective from ineffective drug courts. In short, the findings reveal that drug courts have significantly better outcomes when they (1) treat their optimal target population of high-risk addicted offenders, and (2) avoid diluting the intervention by maintaining careful fidelity to the original drug court model specified in the "10 Key Components of Drug Courts" (NADCP, 1997).

[2] "Heavy use" of alcohol was defined as ≥ 4 drinks per day for women, and ≥ 5 drinks per day for men.

Target Population

High Risk Offenders. No program should be expected to work for all drug-involved offenders. Decades of research in corrections has uncovered a reliable finding known as the *Risk Principle*, in which intensive programs such as drug courts have been shown to have the greatest effects for *high-risk* offenders who have more severe antisocial backgrounds or poorer prognoses for success in standard treatments (e.g., Andrews & Bonta, 2006; Taxman & Marlowe, 2006). Such high-risk individuals ordinarily require a combined regimen of intensive supervision, graduated consequences for misbehavior, and evidence-based treatment services in order to succeed. Low-risk offenders, on the other hand, are less likely to be on a fixed antisocial trajectory and are already predisposed to "adjust course" readily following a run-in with the law. Therefore, intensive treatment and supervision may offer little incremental benefits for these low-risk individuals, but at a substantial cost (DeMatteo, et al., 2006).

Consistent with the predictions of the Risk Principle, drug courts have been proven to have the greatest effects for high-risk drug offenders who were relatively younger, had more prior felony convictions, were diagnosed with antisocial personality disorder, or had previously failed in less intensive dispositions (Lowenkamp et al., 2005; Fielding et al., 2002; Marlowe et al., 2006, 2007; Festinger et al., 2002). In one meta-analysis, the effect size for drug court was determined to be twice the magnitude for high-risk participants as for low-risk participants (Lowenkamp et al., 2005). In another countywide evaluation of drug courts in Los Angeles, virtually all of the positive effects of the drug courts were determined to have been attributable to the higher-risk participants (Fielding et al., 2002).

Importantly, in this context the term "high risk" does *not* refer to a risk for violence or dangerousness, but rather to a risk of failing to respond to standard interventions, and thus for continuing to engage in the same level of drug abuse and crime as in the past. This distinction is crucial because some corrections departments or probation agencies may screen high-risk offenders out of more intensive programs because they perceive them as being a threat to others or somehow less worthy of the services. On the contrary, research reveals that the higher the risk level, the more intensive the services should be. Many high-risk offenders can, in fact, be maintained safely and effectively in the community if they are closely monitored and receive the appropriate dosage of evidence-based services.

High-Need Addicted Offenders. Related to the issue of risk is the issue of *clinical needs*. It is unwarranted to assume that all drug-involved offenders are clinically addicted to drugs or alcohol. In fact, evidence suggests more than half of drug offenders *abuse* or *misuse* substances, but are not addicted (e.g., Fazel et al., 2006). They may repeatedly use drugs or alcohol in ways that are potentially dangerous to themselves or others, but their use is under voluntary control. Addicts, in contrast, suffer from severe cravings or compulsions to use the substance, and may experience painful or uncomfortable withdrawal symptoms whenever they attempt to become abstinent. We now know that these latter symptoms reflect a form of neurological or neuro-chemical damage to the brain, which requires formal treatment intervention (e.g., Baler & Volkow, 2006).

As a result of their brain damage, addicts cannot realistically be expected to respond to the mere threat of punishment. Addicts are notorious for continuing to abuse drugs or alcohol despite experiencing severe and persistent negative consequences. Indeed, patients cannot receive a diagnosis of drug or alcohol dependence unless they continue to use drugs or alcohol in the face of recurrent adverse repercussions (American Psychiatric Association, 2000). A person who readily quits drugs to avoid punishment would, by definition, typically not qualify for the diagnosis of addiction.

For addicted offenders, formal treatment is required to ameliorate their cravings and withdrawal symptoms, provide them with concrete skills to resist drugs and alcohol, and teach them effective coping strategies to deal with life's stressors and challenges (e.g., Chandler et al., 2009). For the drug abuser, on the other hand, threats of punishment might be sufficient to squelch drug use, if several conditions are met: (1) drug use must be reliably detected through urine testing and other means; (2) punishment must be administered with relative certainty and immediacy, and (3) the punishment must be gradually increased in magnitude over time in response to successive infractions. This approach lies at the heart of coerced-abstinence programs such as H.O.P.E. (Hawaii Opportunity Probation with Enforcement), which are showing early promise for enhancing probation outcomes.

Reaching the Target Population. Admittedly, drug courts did not begin by focusing on high-risk addicted offenders. Largely for political reasons, they began as pre-plea diversion programs for first-time drug-possession offenders. Prosecutors — who did not want to appear soft on crime — were generally unwilling to extend this diversionary opportunity to other than the lowest-risk individuals. Unfortunately, judges and other drug court team members had little recourse but to accede to the prosecutors' wishes, because the prosecutor is legally and constitutionally empowered to serve as the "gatekeeper" for such dispositions. Prosecutors enjoy broad and largely unfettered discretion in charging and plea-bargaining practices,[3] and challenges to the prosecutor's gate-keeping function in drug courts have been consistently rebuffed by the appellate courts.[4]

This process has, however, evolved appreciably over the ensuing two decades. As the research evidence indicated that drug courts should be targeting more serious offender populations, they moved decidedly toward treating recidivist and higher-risk participants. In so doing, prosecutors required them to shift their practices to a *post-plea, pre-adjudication* model. Pursuant to this model, defendants are required to plead guilty to the charge(s) or to stipulate to (acknowledge) the facts in the arrest report as a condition of entry. The plea or stipulated agreement is then held in abeyance and may be vacated or withdrawn upon successful completion of treatment. This arrangement provides leverage for drug courts to keep offenders engaged in treatment and ensure they meet their obligations to public safety.

Recently, some advocacy organizations have argued that all drug courts should continue to follow a pre-plea model that does not require a guilty plea for entry (National Association of Criminal Defense Lawyers, 2009). At least one proposed amendment to the drug court reauthorization legislation would require a pre-plea model for all drug courts funded through the DOJ Drug Court Discretionary Grant Program. This proposal is untenable for several reasons. First, without the leverage afforded by a guilty plea, prosecutors will simply go back to permitting only low-level offenders to enter drug courts. In fact, statutes in many jurisdictions do not even permit pre-plea diversion opportunities for serious or recidivist

---

[3] *See* Wayte v. United States, 470 U.S 598 (1985); U.S. v. Armstrong, 517 U.S. 456 (1996).

[4] *See, e.g.,* Woodward v. Morrissey, 991 P.2d 1042, 1045 (Okla. 1999) (holding judicial review of D.A.'s decision to admit defendant to Drug Court would violate separation of powers doctrine); State v. Taylor, 769 So.2d 535, 538 (La. 2000) (finding statutory authorization making prosecutor the initial gatekeeper to Drug Court was proper prosecutorial function which passes constitutional separation of power scrutiny); Flynt v. Commonwealth, 105 S.W.3d 415, 426 (Ky. 2003) (concluding trial court could not permit pre-trial diversion to Drug Court over objection of District Attorney because it would violate constitutional separation of powers doctrine); State v. Diluzio, 90 P.3d 1141 (Wash. App. 2004) (holding prosecutor retained authority to make initial Drug Court referrals pursuant to separation of powers doctrine and consistent with plea bargain powers).

offenders. Because low-level offenders are rarely jail or prison-bound to begin with, such an approach would have no appreciable impact on our prison system, nor would it keep us any safer.

Second, in many jurisdictions offenders can only be placed on probation if they have entered a guilty plea or been convicted. Lacking a plea, judges would not be able to access the intensive level of community supervision that probation departments can provide. Finally, a pre-plea model raises the serious problem of cases going "cold" while offenders are attending treatment. In most drug courts, it takes several months before a noncompliant participant is sanctioned with termination. This is because drug courts typically offer multiple chances for offenders to get and stay clean and sober. After several months, however, the evidence is likely to become stale and witnesses' recollections are apt to fade. Prosecutors therefore understandably want a guilty plea to be entered before allowing defendants several months to engage in trial-and-error efforts at treatment. For all of these reasons, it should be clear that returning to a pre-plea model for drug courts is simply not tenable or desirable.

Most recently, drug courts have also begun to apply a *post-conviction* model for probationers or probation violators, and a *reentry* model for parolees and inmates conditionally released from prison or jail. Because these individuals have already been convicted and sentenced, the prosecution no longer holds sway over the proceedings and the court has greater freedom to fashion a disposition that includes the drug court model. In fact, programs for repeat probation violators are now among the most rapidly developing model of drug courts in the U.S. (Huddleston et al., 2008).

Critics of drug courts might argue that the pace of change has not been rapid or decisive enough. But in the scheme of things in the criminal justice system, 20 years is a miraculously short span of time for any program to take hold across the country, marshal hundreds of empirical studies to identify best practices, and then adapt its fundamental model to align with those best practices. Critics would be hard-pressed to identify any other program that has made such decisive strides within such a short time.

Regardless, more can and should be done to expand eligibility criteria for drug courts. There are still many counties or localities that have elected to treat low-risk, non-addicted individuals on the happenstance that they were arrested for a drug-possession offense. This has the potential to waste scarce treatment and supervision resources, and may unnecessarily deny those services to the very people who need them the most. Under such circumstances, the impact on public health and public safety could be negligible, while the costs could be substantial and prohibitive.

Bear in mind, however, that there are no centralized eligibility standards for drug courts. Like any other sentencing option, drug courts are the product of a negotiated agreement between various agencies within a given county or judicial district. The court, prosecution, defense bar, treatment agencies and probation department must come to mutual terms about what type of program they need and want for their community. So long as prosecutors or judges perceive a political, economic or public-safety risk in accepting more serious offenders, they may resist following the lessons of research. But this problem is in no way specific to drug courts; rather, it applies to *all* criminal justice programs that serve as alternatives to incarceration.

This is where the Federal government could play an important role. Federal grant programs, such as the DOJ Drug Court Discretionary Grant Program, might through their rules and solicitations for funding actively encourage drug courts to serve recidivist offenders, probation violators and parolees. They might further encourage or require drug courts to perform standardized risk-and-needs assessments

using validated assessment tools, and target their services to the higher-risk and higher-need individuals. Grants could be specifically steered toward drug courts that seek out these more serious offender populations. Such seed funding could go a long way toward encouraging experimentation with more serious offenders; and, if the results are as positive as the research would predict, states could be expected to maintain those programs once the federal funding ended.

Federal legislation could also play a role in providing political "cover" for local officials, or at least not exposing them to increased pressure or criticism. For example, the Crime Control Act prohibits the use of federal dollars for drug courts to treat "violent" offenders. There is no empirical justification for this prohibition. Research indicates that violent offenders perform at least as well, and often appreciably better, than other offenders in drug courts — assuming, of course, that drug addiction is fueling their violent behavior (Carey et al., 2008; Saum et al., 2001).

Many people may assume that by denying drug court to violent offenders, they are instead kept locked up. But that is not the case. Most violent offenders are returned to their community fairly rapidly, often within a few months or years. Offenses such as simple assault, domestic violence, vehicular assault and stalking often do not receive very long sentences to begin with, and prison and jail overcrowding have had the practical effect of causing many violent inmates to be released prematurely. Denying these offenders access to drug court means, in effect, that they are likely to receive *less* community supervision than a simple drug-possession offender. This makes no sense. If violent offenders are to be released into the community (and many are), then intensive programs such as drug courts are exactly where they ought to be. Federal legislation should drop the categorical violence exclusion and should encourage drug courts to make greater contributions to public safety by taking on those individuals who pose the greatest threats to their communities.

Fidelity to the 10 Key Components

In fiscally challenging times, there is always the pressure to do more with less. And there is no shortage of policy advocates asserting that they can serve large numbers of drug offenders at a reduced cost. These too-good-to-be-true promises are just that. If there is one lesson that researchers and program evaluators have learned from bitter experience, it is that there are no easy short cuts for treating high-risk, drug-addicted offenders. Every effort to water-down what we know to be the essential ingredients for success has been met not only with disappointment, but sometimes with outright harm. Poor-quality programs may not merely fail to help, they can make matters worse.

Examples of this abound in the research literature. Proposition 36 in California diverted large numbers of drug-possession offenders into treatment in lieu of incarceration, and the courts were effectively disabled from responding to noncompliance with appreciably more than an extension of probation and relatively toothless demands for more treatment. Lacking adequate behavioral contingencies, including graduated sanctions, the results were predictably lackluster. Roughly one-quarter of the offenders never arrived for a single treatment session, 50 percent of those who did arrive for treatment dropped out in less than 3 months, and only one quarter ever completed treatment (UCLA, 2007). Worse still, criminal recidivism actually increased. Re-arrest rates for drug and property offenses were significantly higher among Proposition 36 participants than among comparably matched drug offenders who did not participate in Proposition 36 (Farabee et al., 2004; UCLA, 2007).

Similarly, a program known as Project Greenlight in New York City offered treatment services for parolees, but little else in the way of supervision or accountability after release. The results there, too, were painfully disappointing, including increased re-arrest rates, probation violations and revocations (Wilson & Davis, 2006; see also Marlowe, 2006).

Drug courts have been forced to learn these same lessons. Drug courts that have held fast to the original drug court model and maintained the full panoply of services denoted in the 10 Key Components have had positive outcomes and returned financial benefits to their communities that were several times the initial investments. Those that dropped central ingredients of the model or reduced the dosage of services have had less beneficial effects or sometimes caused more harm than good.

The "10 Key Components" of drug courts include, but are not limited to: (1) a multidisciplinary team approach to managing cases, (2) an ongoing schedule of judicial status hearings, (3) weekly drug testing, (4) contingent sanctions and incentives, and (5) a standardized regimen of substance abuse treatment (NADCP, 1997). Each of these hypothesized key components has been studied by researchers or evaluators to determine whether it is, in fact, necessary for effective results. The results have confirmed that fidelity to the full drug court model is necessary for optimum outcomes — assuming, again, that the programs are treating their correct target population of high-risk, addicted offenders.

Multidisciplinary Team Approach. One of the more novel features of drug courts is the practice of having professionals from various disciplines meet regularly to coordinate their functions as a team (NADCP, 1997). At regularly scheduled staff meetings, which are held before the court sessions, the various team members contribute information from their perspectives about the participants' progress in the program and may offer recommendations for suitable responses, such as rewards, sanctions or changes to the participants' treatment plans.

Research confirms that the most effective drug courts require regular attendance by the judge, defense counsel, prosecutor, treatment providers and law enforcement officers at the staff meetings and court hearings (Carey et al., 2008). When any one of these professional disciplines was regularly absent from team discussions, the programs tended to have outcomes that were, on average, approximately 50 percent less favorable (Carey et al., in press). In other words, if any one professional discipline is excluded from the intervention, there is reason to anticipate the effectiveness of a drug court could be cut by as much as one half.

There should be nothing surprising about this finding. Addiction and associated crime are severe and chronic conditions that require an intensive and coordinated response. No one profession could be expected to have the knowledge, expertise and authority to deal effectively with this intransigent social problem. It should not be surprising that a coordinated team approach involving the continuous input of several professional disciplines would be required to intervene effectively with high-risk drug-addicted offenders.

Judicial Status Hearings. Unlike traditional court proceedings, participants in drug courts attend status hearings in court, during which the judge regularly reviews their progress in treatment and may impose a range of consequences contingent upon their performance. Research unequivocally demonstrates that judicial status hearings are an indispensible element of the success of drug courts (Carey et al., 2008; Festinger et al., 2002; Marlowe et al., 2004a, 2004b, 2006, 2007). The optimal schedule appears to be no less frequently than bi-weekly hearings for at least the first phase (first several

months) of the program. It seems that the power and authority of a judge may be necessary to gain control over high-risk addicted offenders' behaviors and keep them regularly engaged in treatment.

Drug Testing. The most effective drug courts perform drug testing at least twice per week during the first several months of the program (Carey et al., 2008). Because the metabolites of most common drugs of abuse remain detectable in human bodily fluids for only about one to four days, testing less frequently leaves an unacceptable time gap during which participants can use drugs and evade detection. In addition, drug testing is most effective when it is performed on a random basis. If participants know in advance when they will be drug tested, they may adjust their usage accordingly or take other countermeasures in an effort to beat the tests. Programs that do not perform random, twice-weekly drug testing are simply not engaged in effective evidence-based practices.

Graduated Sanctions & Rewards. The pervasive perception among both staff members and participants in drug courts is that punitive sanctions for infractions and rewards for achievements are strong motivators of positive behavioral change (Lindquist et al., 2006; Goldkamp et al., 2002; Harrell & Roman, 2001; Farole & Cissner, 2007). Two randomized controlled experiments have confirmed that the imposition of swift, certain, and gradually escalating sanctions for infractions, including brief intervals of jail detention, significantly improves outcomes among drug offenders (Harrell et al., 1999; Hawken & Kleiman, 2009).

This is the central approach employed in coerced-abstinence programs such as H.O.P.E., but it is also one critical ingredient of the drug court model. In fact, drug courts were the *first* to apply this approach in day-to-day criminal justice practice. Drug courts view graduated sanctions as one component of a multi-component model, whereas other programs may rely primarily on this specific intervention to achieve their effects.

Substance Abuse Treatment. As discussed earlier, punishment, or the threat of punishment, alone may be effective at reducing substance abuse among non-addicted drug abusers; however, it is unlikely to elicit long-term change among addicted individuals without the addition of evidence-based treatment services. Formal treatment is required to ameliorate addicts' cravings and withdrawal symptoms, provide them with concrete skills to resist drugs and alcohol, and teach them effective coping strategies to deal with life's stressors and challenges. This is the conclusion of the National Institute on Drug Abuse in its guiding criminal justice document, *Principles of Drug Abuse Treatment for Criminal Justice Populations* (NIDA, 2006).

Significantly better outcomes have, in fact, been achieved when drug courts adopted standardized evidence-based treatments, which go by such names as Moral Reconation Therapy (MRT; Heck, 2008; Kirchner & Goodman, 2007), the MATRIX Model (Marinelli-Casey et al., 2008) and Multi-Systemic Therapy (MST; Henggeler et al., 2006); as well as culturally proficient services (Vito & Tewksbury, 1998). What all of these evidence-based treatments share in common is that they are highly structured, are clearly specified in a manual or workbook, apply behavioral or cognitive-behavioral interventions, and take participants' communities of origin into account.

The results of this substantial body of research demonstrate beyond peradventure that treatment is not a dispensable element of criminal justice policy. For individuals suffering from the brain damage known as addiction, punishment is not enough. They also need formal evidence-based treatment.

TAKING DRUG COURTS TO SCALE

There is no question that drug courts are, at best, serving only about 5 to 10 percent of the high-risk, addicted, prison-bound offender population. According to NADCP's most recent data, which have not yet been published, there are roughly 110,000 to 120,000 individuals currently in drug courts. The Urban Institute estimates there are approximately 1.5 million potentially prison-bound arrestees each year in the U.S. who are "at risk" for drug dependence or abuse (Bhati et al., 2008).

Data are lacking to know precisely what proportion of those arrestees are clinically addicted to drugs or alcohol, at high-risk for failure in standard treatment, and meet other (rational) eligibility criteria for drug courts. Regardless, the sum is obviously many times the current drug court census. And that does not include the huge number of individuals who are already under correctional supervision on probation or parole, or are in our jails and prisons and about to be released back into our communities.

The time has come to fill the service-gap for this large population of high-risk, drug-addicted individuals who require drug court services to become sober, law-abiding and productive citizens. Before policymakers pursue the latest program du jour, with promises of high returns on small up-front investments, consider the five meta-analyses, hundreds of scientific studies, and decades of professional experience and wisdom emanating from drug courts. The GAO (2005) and NIJ (2006) have each reviewed the scientific evidence and concluded that drug courts work. What other program for drug offenders can say that? The current Administration is committed to supporting and promoting "what works" and endorsing evidence-based practices. Drug courts are the very definition of this concept.

Some policy advocates argue that we should infuse drug court precepts and practices throughout the justice system, including in the traditional criminal courts, probation and parole agencies, and corrections departments. No one could argue with that proposition. But underlying this position, in some cases, is the goal of watering down or fundamentally altering the intervention. The sad truth is that many effective programs have, in the due course of policy administration, been made cheaper simply by lowering the dosage or providing fewer services to more participants. In many cases, effectiveness was lost as a result and then chalked up to a "failure to replicate." The success of drug courts has already been replicated hundreds of times across the country. That is what meta-analysis tells us. Cheapening or weakening the model, therefore, is by definition not evidence-based. If advocates want to propose an alternative model that provides less service, then the burden of proof falls squarely upon them to prove that their alternative is as effective and safe as the current standard of care, which is drug court.

A Criminal Justice Continuum of Care

This does *not* mean that all drug-involved offenders should be in drug courts. As was already discussed, research indicates the drug court model is unnecessary or unsuited for low-risk offenders, and for non-addicted drug abusers. It may also not be suited, or may require substantial modifications, for other types of offender populations, such as sex offenders.

Coerced-abstinence programs like H.O.P.E. hold considerable promise for intervening with non-addicted offenders, including those who are high-risk. In addition, programs such as California's Proposition 36, which focus on treatment rather than accountability, might hold promise for low-risk addicted offenders. There are plenty of drug-involved offenders to go around, and the critical task now is to determine, empirically, which types of offenders should go into which types of programs.

This is where *risk and needs assessment* comes in. When our criminal justice system moved from indeterminate sentencing to determinate sentencing a few decades ago, the practical effect was to render pre-sentencing investigations (PSI's) essentially irrelevant. If sentences were to be based almost exclusively on the nature of the current charge and past convictions, rather than on the characteristics of the offender, then offender-based assessments were largely a waste of time and resources.

Research now demonstrates that offender-based assessments, when properly validated and standardized, can greatly enhance correctional outcomes by matching offenders to the best programs and services. And recent case-law precedent at the state and Federal levels permits or requires greater discretion in sentencing based, in part, on offender characteristics. The newest draft of the Model Penal Code includes risk and needs factors as fodder in sentencing determinations, and many states are beginning to follow suit.

The U.S. Sentencing Commission, with guidance from Congress, should require risk-and-needs assessments to be performed and considered in sentencing decisions. In addition to (not instead of) taking other value-laden issues into consideration, such as victims' sentiments and society's legitimate interest in general deterrence, judges, defense counsel and prosecutors should be encouraged, if not required, to include data on effectiveness and cost-effectiveness in their calculus of decision-making when advocating for or rendering sentencing dispositions.

Ideally, risk-and-need information should be explicitly referenced in sentencing guidelines or statutes as permissible or mandatory factors to be considered in sentencing. Congress can lead by encouraging amendments to the U.S. Sentencing Guidelines in this regard. Congress can also lead by providing grants to the states through DOJ and other agencies to amend their sentencing laws to require consideration of this information, to develop procedures to streamline the availability of risk-and-needs assessment information, to empirically validate assessment tools, and to measure the actual effects of various sentencing frameworks to determine which approaches are most effective at reducing recidivism, saving money and saving lives.

Science has advanced greatly in recent decades. We know a lot more now than we did in the 1970s, 1980s and 1990s. We know the basic parameters for intervening effectively with drug-involved offenders in community-based settings. We know how to supervise them closely, reliably detect drug use, apply graduated sanctions and incentives effectively, and treat the underlying disease of addiction where it is present. Unfortunately, our laws and policies have not kept pace. They are still based on outdated sentiments from decades past, when we didn't know much about the disease of addiction, how to perform valid risk-and-needs assessments, and how to develop effective treatment and supervision care plans. If Congress leads in infusing science into policy, the states and the country will follow.

I want to again thank this august Committee for the opportunity to address you on these critically important issues for our nation's domestic agenda. I am happy to answer any questions you may have and to provide relevant supporting documentation for the scientific facts I have asserted.

Respectfully submitted,

Douglas B. Marlowe, J.D., Ph.D.
Chief of Science, Law & Policy
National Association of Drug Court Professionals

Research Cited

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disor*ders (4th ed., text rev.) [DSM-IV-TR]. Washington DC: American Psychiatric Press.

Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Cincinnati: Anderson.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates.* Olympia, WA: Washington State Institute for Public Policy.

Baler, R. D., & Volkow, N. D. (2006). Drug addiction: The neurobiology of disrupted self-control. *Trends in Molecular Medicine, 12*, 559-566.

Barnoski, R,. & Aos, S. (2003). *Washington State's drug courts for adult defendants: Outcome evaluation and cost-benefit analysis.* Olympia, WA: Washington State Institute for Public Policy.

Belenko, S., Patapis, N., & French, M. T. (2005). *Economic benefits of drug treatment: A critical review of the evidence for policy makers.* Missouri Foundation for Health, National Rural Alcohol & Drug Abuse Network.

Bhati, A. S., Roman, J. K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders.* Washington, DC: The Urban Institute.

Carey, S. M., Finigan, M., Crumpton, D., & Waller, M. (2006). California drug courts: Outcomes, costs and promising practices: An overview of phase II in a statewide study. *Journal of Psychoactive Drugs, SARC Supplement 3,* 345-356.

Carey, S. M., Finigan, M. W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs.* Portland, OR: NPC Research. *Available at* www.npcresearch.com.

Carey S. M., Waller, M., & Weller, J. (in press). *California drug court cost study - Phase III: Statewide costs and promising practices, final report.* Portland, OR: NPC Research.

Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301,* 183-190.

DeMatteo, D. S., Marlowe, D. B., & Festinger, D. S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency, 52,* 114-134.

Farabee, D. et al. (2004). Recidivism among an early cohort of California's Proposition 36 offenders. *Criminology & Public Policy, 3,* 563.

Farole, D. J., & Cissner, A. B. (2007). Seeing eye to eye: Participant and staff perspectives on drug courts. In G. Berman, M. Rempel & R. V. Wolf (Eds.), *Documenting Results: Research on Problem-Solving Justice* (pp. 51-73). New York: Center for Court Innovation.

Fazel et al. (2006). Substance abuse and dependence in prisoners: A systematic review. *Addiction, 101*, 181-191.

Festinger, D. S., Marlowe, D. B., Lee, P. A., Kirby, K. C., Bovasso, G., & McLellan, A. T. (2002). Status hearings in drug court: When more is less and less is more. *Drug & Alcohol Dependence, 68*, 151-157.

Fielding, J. E., Tye, G., Ogawa, P. L., Imam, I. J., & Long, A. M. (2002). Los Angeles County drug court programs: Initial results. *Journal of Substance Abuse Treatment, 23*, 217-224.

Finigan, M., Carey, S. M., & Cox, A. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs*. Portland, OR: NPC Research. *Available at* www.npcresearch.com

Goldkamp, J. S., White, M. D., & Robinson, J. B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter, 6*, 369-372.

Gottfredson, D. C., Kearley, B. W., Najaka, S. S., & Rocha, C. M. (2005). The Baltimore City Drug Treatment Court: 3-year outcome study. *Evaluation Review, 29*, 42-64.

Gottfredson, D. C., Najaka, S. S., Kearley, B. W., & Rocha, C. M. (2006). Long-term effects of participation in the Baltimore City drug treatment court: Results from an experimental study. *Journal of Experimental Criminology, 2*, 67-98.

Harrell, A., Cavanagh, S., & Roman, J. (1999). *Final report: Findings From the Evaluation of the D.C. Superior Court Drug Intervention Program.* Washington, DC: The Urban Institute.

Harrell, A., & Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues, 31*, 207-232.

Hawken, A., & Kleiman, M. (2009). Managing drug involved probationers with swift and certain sanctions: Evaluating Hawaii's HOPE [NCJRS no. 229023]. Washington DC: National Institute of Justice. Available at http://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf.

Heck, C. (2008). MRT: Critical component of a local drug court program. *Cognitive Behavioral Treatment Review, 17(1)*, 1-2.

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., Shapiro, S. B., & Chapman, J. E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting & Clinical Psychology, 74*, 42-54.

Huddleston, C. W., Marlowe, D. B., & Casebolt, R. (2008, May). *Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States* [Vol. II, No. 1]. Alexandria, VA: National Drug Court Institute.

Kirchner, R. A., & Goodman, E. (2007). Effectiveness and impact of Thurston County, Washington drug court program. *Cognitive Behavioral Treatment Review, 16(2)*, 1-4.

Latimer, J., Morton-Bourgon, K., & Chretien, J. (2006). *A meta-analytic examination of drug treatment courts: Do they reduce recidivism?* Canada Dept. of Justice, Research & Statistics Division.

Lindquist, C. H., Krebs, C. P., & Lattimore, P. K. (2006). Sanctions and rewards in drug court programs: Implementation, perceived efficacy, and decision making. *Journal of Drug Issues, 36*, 119-146.

Lipsey, M. W., & Wilson, D. B. (2001). *Practical meta-analysis*. Thousand Oaks, CA: Sage.

Logan, T. K., Hoyt, W., McCollister, K. E., French, M. T., Leukefeld, C., & Minton, L. (2004). Economic evaluation of drug court: Methodology, results, and policy implications. *Evaluation & Program Planning*, 27, 381-396.

Loman, L. A. (2004). *A cost-benefit analysis of the St. Louis City Adult Felony Drug Court*. St. Louis, MO: Institute of Applied Research.

Lowenkamp, C. T., Holsinger, A. M., & Latessa, E. J. (2005). Are drug courts effective? A meta-analytic review. *Journal of Community Corrections, Fall*, 5-28.

Marinelli-Casey, P., Gonzales, R., Hillhouse, M., et al. (2008). Drug court treatment for methamphetamine dependence: Treatment response and post-treatment outcomes. *Journal of Substance Abuse Treatment, 34*, 242-248.

Marlowe, D. B. (2006). When "what works" never did: Dodging the "Scarlet M" in correctional rehabilitation. *Criminology & Public Policy, 5*, 601-608.

Marlowe, D. B., Festinger, D. S., Dugosh, K. L., Lee, P. A., & Benasutti, K. M. (2007). Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study. *Drug & Alcohol Dependence, 88S*, 4-13.

Marlowe, D. B., Festinger, D. S., & Lee, P. A. (2004a). The judge is a key component of drug court. *Drug Court Review, 4 (2)*, 1-34.

Marlowe, D. B., Festinger, D. S., & Lee, P. A. (2004b). The role of judicial status hearings in drug court. In K. Knight & D. Farabee (Eds.), *Treating addicted offenders: A continuum of effective practices* (chap. 11). Kingston, NJ: Civic Research Institute.

Marlowe, D. B., Festinger, D. S., Lee, P. A., Dugosh, K. L., & Benasutti, K. M. (2006). Matching judicial supervision to clients' risk status in drug court. *Crime & Delinquency, 52*, 52-76.

National Association of Criminal Defense Lawyers. (2009). *America's problem-solving courts: The criminal costs of treatment and the case for reform*. Washington DC: Author.

National Association of Drug Court Professionals. (1997). *Defining drug courts: The key components*. Washington, DC: Office of Justice Programs, U.S. Dept. of Justice.

National Institute on Drug Abuse. (2006). *Principles of Drug Abuse Treatment for Criminal Justice Populations* [NIH Pub. No. 06-5316]. Bethesda, MD: Author.

National Institute of Justice. (2006). *Drug Courts: The Second Decade*. Washington DC: Author.

Pew Center on the States. (2008). *One in 100: Behind Bars in America 2008*.

Rempel, M., & Green, M. (2009, November). *Do drug courts reduce crime and produce psychosocial benefits?* Presentation at the 2009 Annual Conference of the American Society of Criminology, Philadelphia, PA.

Rossman, S. B., Green, M., & Rempel, M. (2009, November). *Substance abuse findings from the Multi-Site Adult Drug Court Evaluation (MADCE)*. Presentation at the 2009 Annual Conference of the American Society of Criminology, Philadelphia, PA.

Saum, C. A., Scarpitti, F. R., & Robbins, C. A. (2001). Violent offenders in drug court. *Journal of Drug Issues, 31*, 107-128.

Shaffer, D. K. (2006). *Reconsidering drug court effectiveness: A meta-analytic review*. Reno: Dept. of Criminal Justice, University of Nevada.

Taxman, F. S., & Marlowe, D. B. (Eds.) (2006). Risk, needs, responsivity: In action or inaction? [Special Issue]. *Crime & Delinquency, 52(1)*.

Turner, S., Greenwood, P. Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review, 2*, 61-85.

U.S. Government Accountability Office. (2005). *Adult drug courts: Evidence indicates recidivism reductions and mixed results for other outcomes* [No. GAO-05-219]. Washington, DC: Author.

University of California, Los Angeles. (2007). *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report*. UCLA Integrated Substance Abuse Programs.

Vito, G. F., & Tewksbury, R. A. (1998). The impact of treatment: The Jefferson County (Kentucky) drug court program. *Federal Probation, 62*, 46-51.

Wilson, D. B., Mitchell, O., & MacKenzie, D. L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology, 2*, 459-487.

Wilson, J. A., & Davis, R. C. (2006). Good intentions meet hard realities: An evaluation of the Project Greenlight reentry program. *Criminology & Public Policy, 5*, 303-338.

Mr. KUCINICH. Thank you, Mr. Marlowe.
Mr. Abrahamson.

STATEMENT OF DANIEL N. ABRAHAMSON

Mr. ABRAHAMSON. Thank you, Mr. Chair, for inviting me to speak today. I am going to speak about California's Substance Abuse and Crime Prevention Act of 2000, which represents the most significant piece of sentencing reform legislation in terms of the number of people diverted from incarceration and the dollars saved since the repeal of alcohol prohibition in 1933.

Now, Prop 36 came about as a direct response to the shortcomings of California's drug courts. Those shortcomings included severe restrictions on who got access to drug courts, prosecutors and judges frequently cherry-picking clients for the program, who they thought would be most likely to succeed, as opposed to those were most in need of drug treatment.

Another problem with drug courts was judges, not treatment professionals, making decisions about appropriate treatment placements. Relatedly, a vast majority of California drug court judges, and this is true, I think, across the United States, denied opiate-dependent persons access to the most successful and proven treatments for their condition, namely methadone and buprenorphine.

Finally, drug courts in California frequently used jail sanctions to respond to drug use relapse even though relapse is a natural condition in part of being addicted.

Prop 36 sought to create a more health-centered approach to drug treatment within the criminal justice system. To this end, Prop 36 eliminated cherry-picking of clients by making eligible all persons convicted of non-violent drug possession offenses who did not have a recent history of violence. Treatment professionals determine appropriate treatment placements. And medically assisted treatments such as methadone and buprenorphine cannot be denied persons who need them.

Further, drug testing is used solely as a treatment tool, not as a grounds to impose punitive sanctions. And in fact, Prop 36 prohibits the imposition of short-term jail sanctions to respond to drug-related violations such as drug use relapse.

Prop 36 is perhaps the most rigorously evaluated treatment diversion program in the country. Over a series of 5 years, researchers at the University of California and elsewhere collected data, crunched it and published it. Their findings include the following: 36,000 people a year in California took advantage of Prop 36, roughly 10 times the number that were eligible and took advantage of drug courts in California.

Importantly, one half of all clients entering Prop 36 had never accessed drug treatment before. This was their first option and opportunity to get drug treatment. Moreover, Prop 36 treated persons with very serious addictions. Over one half of all Prop 36 clients had used drugs on average of 11 or more years. These were not low-level, first-time drug users. And in fact, over half, or roughly half of Prop 36 clients were there for methamphetamine use. And they succeeded in completing the program at the same rates as other drug users in Prop 36.

Importantly, completion rates for Prop 36 ranged, from county to county, from 30 to 60 percent, which is almost exactly on par with the range of success rates of drug courts, both in California and nationally. And as UCLA itself reported, $2 to $4 was saved for every $1 invested in Prop 36.

In short, we believe that Prop 36 represents an important improvement upon drug courts as they then existed in California.

But to end the discussion here would be misleading. In the larger scheme of things, drug courts and Prop 36 are simply stop-gap measures, and they always will be. As long as 1.4 million people are arrested every year for nothing more than simple drug possession, drug cases will continue to swamp the criminal justice system and cause unnecessary misery. Neither Prop 36 nor drug courts can solve or even adequately mitigate the systemic problems created by continued massive low-level drug arrests.

Tinkering with alternatives to incarceration within the criminal justice system will help some people. But it will fail a far greater number of others. Mr. Chairman, we need to move beyond drug courts to consistent, health-centered approach to drug use. We need to end the criminalization of simple drug use and provide treatment to drug users outside the criminal justice system.

Thank you.

[The prepared statement of Mr. Abrahamson follows:]

Daniel N. Abrahamson

Director of Legal Affairs

Drug Policy Alliance

Domestic Policy Subcommittee
Of the
Oversight and Government Reform Committee

Thursday, July 22, 2010
2154 Rayburn
2:00 p.m.

"Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders"

Good morning. I'm Daniel Abrahamson, director of legal affairs for the Drug Policy Alliance, the nation's leading organization advocating alternatives to the failed war on drugs. I want to thank the subcommittee for inviting me to testify on alternatives to incarceration for drug-using people within the criminal justice system. As a co-author of California's voter-approved, treatment-instead-of-incarceration law, I will focus on the genesis of that law – known both as Proposition 36 and the Substance Abuse and Crime Prevention Act, 2000 – as well as its role over the last ten years in expanding access to treatment, reducing incarceration, and cutting state costs.

I will also address alternatives to incarceration – primarily Proposition 36, drug courts and HOPE – through a broader policy lens. For two decades, the question has been: Do drug courts work? The Drug Policy Alliance would pose the larger question: What works best? In brief, the policy conversation on alternatives to incarceration has been too narrow and focused almost exclusively within the criminal justice system. We urge a more robust discussion aimed at

identifying ways to further reduce the role of the criminal justice system – and increase the role of public health and medicine – in responding to drug use, a quintessential health issue.

Proposition 36, California's Landmark Treatment-Instead-of-Incarceration Law

In November 2000, California voters approved a landmark statewide measure, called the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36), that requires the state to provide drug treatment, rather than jail or prison time (or probation without treatment), for most people convicted of a first or second drug possession offense. Prop 36 remains the most significant piece of sentencing reform – in terms of the number of people diverted from prison and dollars saved – since the repeal of alcohol Prohibition in 1933.

The problem, before Prop 36, was that too many people in California did not have access to treatment before they faced jail or prison sentences for simple drug possession. As the nation's war on drugs intensified in the 1980s and '90s, California followed national trends by relying increasingly on punishment and prisons as its primary response to arrests for illicit drug use. During that same time, spending on community-based drug treatment remained flat. Hundreds of thousands of people were arrested, convicted and imprisoned for a personal drug possession offense, disrupting families and dimming future employment prospects. As a result, between 1988 and 2000, the number of people imprisoned in California for drug possession quadrupled.

Since its passage, Prop 36 has:

Provided treatment to 30,000+ people a year. Over 300,000 people have entered community-based treatment under Prop 36, half of whom had never received treatment before. About one-third of participants complete treatment and probation; about half stay for at least 90 days, "the minimum threshold for beneficial treatment."[1]

Sharply reduced the number of people in state prison for simple drug possession. In the 12 years prior to Prop 36, the number of people in state prison for drug possession quadrupled, peaking at 20,116 in June 2000. That number dropped by one-third shortly after Prop 36 took effect, and remained lower by 8,000 (40%) as of December 2008.[2]

Reduced state costs by over $2 billion. For every $1 invested in Prop 36, the state saves a net $2.50-$4[3]. Average per-person treatment costs are about $3,300, while incarceration costs $49,000 per year. The University of California at Los Angeles (UCLA) calculated that the program cut costs by $173 million its first year; the Legislative Analyst's Office put annual savings for later years at $200-300 million.

Achieved expected rates of "progress" and "completion". According to UCLA, Prop 36 completion rates are "fairly typical" of drug users referred to treatment by the criminal justice system.[4] The statewide completion rate reached 40% in 2007. At the county level, Prop 36 completion rates range from 26% to over 50%.

Did not lead to increased crime. According to UCLA, despite diverting over 36,000 people to probation and drug treatment each year, Prop 36 has had no negative impact on crime trends.[5]

Importantly, Prop 36 achieved these results *without* exclusionary gatekeeping by prosecutors or judges, punitive drug testing, short-term jail sanctions or dedicated court calendars – all components often declared to be critical to the operation of drug courts.[6] Prop 36 also expressly allows for participants to receive narcotic replacement therapy, the gold-standard of opoid treatment, which is unfortunately still barred in the vast majority of drug courts.

Prop 36 represents a positive modification of drug courts, taken to scale. In 2001-2006, when Prop 36 was funded at $120 million a year, 36,000 people were enrolled annually[7] (nearly ten times the number in all of California's drug courts and more than one-half of all people admitted to drug courts nationwide each year)[8] and completion rates were comparable to those of other criminal justice programs.[9] An estimated $2,861 was saved per participant, or $2.50 for every dollar invested,[10] and there was no adverse effect on crime trends.[11]

However, even with these outcomes, California – like all other states – has continued to incarcerate people for personal drug possession, either because they are ineligible for the program or because they are unable to stop using drugs. Indeed, as long as drug use remains criminalized, the people most likely to be incarcerated for drug possession offenses are those who struggle most mightily with their addictions.

Drug Courts Help People *And* Perpetuate the Criminalization of Addiction

There is no doubt that drug courts were created and continue to be run with unflagging dedication and concern for the health and wellbeing of individuals and communities. Nor is there any question that drug court judges and their staffs have helped change, even save, many lives. Indeed, there is no shortage of success stories.

The issue, however, is not whether drug courts do some good – they undoubtedly do – but rather whether the proliferation and expansion of drug courts is good social policy as compared with other available approaches and interventions to address drug use. We find that, based on the published evidence to date, drug courts produce more costs than they do benefits at a policy level.

The NIJ's Multi-Site Adult Drug Court Evaluation (MADCE) study currently under way should help begin to address some of the questions that previous research has left unanswered.[12] The limited drug court research literature that is both available and methodologically-sound reveals significant shortcomings in drug court practices – for example, "cherry picking" of clients most likely to succeed, poor treatment options for clients, and woefully inadequate access to effective therapies for opioid dependence (including methadone) – and drug court outcomes – for example, no reduction and possible increase in incarceration rates, and little or no cost savings.

The available drug court literature suggests that although many individuals will benefit from drug courts each year, many others may ultimately be worse off than if they had access to health services, had been left alone, or even been conventionally sentenced. In short, drug courts, as currently devised, may provide little or no benefit over the wholly punitive system they intend to improve upon.

Certainly, the national drug court movement is trying to improve practices and outcomes. The National Association of Drug Court Professionals, for example, encourages courts to allow participants access to narcotic replacement therapies, emphasizes that incentives are as important as sanctions and urges drug courts to identify and implement best practices as they are identified.

There is no getting around the fact, however, that drug courts can only exist as long as drug use is criminalized. And, while drug courts will help some, many more will continue to be arrested and incarcerated for their drug use.

Roughly 55,000 people enter the more than 2,100 drug courts in the U.S. annually,[13] representing a tiny fraction of the 1.8 million people arrested on drug charges.[14] With drug court completion rates ranging widely from 30 percent to 70 percent,[15] somewhere between 16,500 and 38,500 will graduate. The rest are deemed to have "failed." Even if drug courts were expanded to cover all people arrested for drug possession, between 500,000 and 1 million people would still be ejected from a drug court and sentenced conventionally every year.[16]

This is the drug court paradox. Drug courts are grounded in two contradictory models. The disease model assumes that people who misuse drugs are unable to think rationally about their drug use.[17] It is therefore the state's duty to compel people into treatment. The rational actor model, which underlies principles of punishment, assumes that people weigh the benefits of their actions against the potential consequences of those actions.[18]

These dueling models result in people being "treated" through a medical lens while the symptoms of their condition – chiefly, the inability to maintain abstinence – are addressed through a penal one. The person admitted into drug court is regarded as not fully rational and only partially responsible for their drug use; yet the same person is considered rational and responsible when they do not respond to the carrots and sticks of drug court.[19]

Short-term jail sanctions for drug relapse and the punitive use of drug testing are two central practices of drug courts that lack evidentiary support and are deeply problematic. Though drug courts vary in their practices, the use of short jail sanctions, or "flash incarceration" to punish clients who use drugs or violate program rules is standard. The power of drug court judges to order the incarceration of people who do not abstain from drug use is thought by many drug court proponents to be a critical component of drug court success. However, as the California Society of Addiction Medicine has noted, not a single study has shown that incarceration sanctions improve substance use treatment outcomes.[20] (Or, as UCLA researchers put it, "the benefits of flash incarceration are not well established."[21])

Treatment retention is consistently and positively linked to treatment readiness[22] as well as marital bonds, employment and education.[23] Jail sanctions, however, have been associated with a higher likelihood of re-arrest and a lower probability of program completion.[24] A person's sense of autonomy and motivation – integral to progress in treatment – can be undermined if they feel they are sanctioned unfairly.[25] Moreover, for days or weeks at a time, flash incarceration places a person who is struggling with drugs into a stressful, violent and humiliating environment, where drugs are often available (and clean syringes almost never), where sexual violence is common (and condoms rare), where HIV, hepatitis C, tuberculosis and other communicable diseases are

prevalent, where medical care is often substandard, and where drug treatment is largely nonexistent.

In drug court, jail sanctions for drug relapse interrupt the treatment process, disrupt a person's attempts to maintain employment and stable social bonds, and reinforce the notion that the person is deviant. The pain, deprivation and atypical, dehumanizing routines that people experience while incarcerated can create long-term negative consequences.[26]

Drug testing can be an important tool in the treatment process. Drug courts, however, often rely on drug test results as the main, if not sole, factor for assessing the progress of clients in the program. When used thus, drug tests are transformed from a tool to determine how well a treatment regimen is working into a stand-alone measure of success or failure. The over-emphasis of drug test results by drug courts can often lead to negative consequences for clients, including the improper imposition of jail sanctions and lower rates of full-time employment.[27] Of particular concern, drug testing can trigger a cat-and-mouse game where the client's goal is to beat the test. For example, some youth who are subjected to frequent drug testing in juvenile drug courts have reported switching from using drugs that are frequently and easily tested for, such as marijuana, to drugs that metabolize more quickly and so are more difficult to detect, such as cocaine, methamphetamine, or opiates such as heroin.[28]

Under the drug court approach, those suffering more serious drug problems are most likely to "fail" drug court and be punished.[29] In the end, the person who has the greatest ability to control his or her own drug use will be much more likely to complete treatment and be deemed a "success."

With drug courts, there is also significant opportunity cost. Drug courts appear to have flourished at the expense of support services that are more accessible and that are more effective at improving health and reducing crime.[30] Absent efforts to help people *before* they are in crisis and absent policies to stem the flow of people into the criminal justice system for petty drug law violations, drug courts and other criminal justice-based treatment programs (including Prop 36) will not meaningfully reduce the harms of drug use or the use of imprisonment.[31]

Short-Term Reforms Urgently Needed

As long as drug courts aim to "treat" addiction within the criminal justice system, they should adopt more health-oriented practices, offer proven health interventions, and focus their treatment resources on persons who would otherwise face lengthy terms of incarceration. Improvements include:

- Focusing drug court resources on more seriously criminally-involved people to ensure that drug court is actually a diversion from incarceration and not more restrictive than the conventional sentence;[32]
- Using a pre-plea rather than a post-plea model;[33]
- Adopting objective admission/eligibility criteria and reducing the prosecutor's role as gate-keeper to treatment;[34]
- Ensuring due process protections and enhance the role of defense counsel;[35]

- Empowering treatment professionals in decision-making;
- Improving data collection and rigor of research;[36]
- Using drug tests as a treatment tool, not as punishment;
- Prohibiting the use of jail sanctions for drug relapse;
- Adopting a wider range of health measures – not simply abstinence – into program goals;
- Employing evidence-based practices, such as opioid maintenance treatments;
- Ensuring that practices are more health-oriented than punitive; and
- Ensuring that punishment for "failing" the program is not worse than the original penalty for the offense.

While these changes would help improve the functioning, transparency and accountability of drug courts, policymakers must also ask whether, *as long as drug use is criminalized,* probation or parole departments could oversee low-level offenders in community-based treatment in a less costly and equally effective way than drug courts.

Neither Drug Courts nor the "HOPE" Program are Public Health Approaches to Drug Use

Public health interventions to address problematic drug use are wise, necessary long-term investments. They reduce the harms associated with drug use, prevent crime against people and property, and cut associated costs.[37] We recommend reducing the role of the criminal justice system in addressing drug use and emphasizing a health-centered approach instead.

Some states have demonstrated steps toward a health approach to drug use by rolling back the most punitive drug sentencing policies. However, these changes fall short of what is needed: an end to the criminalization of drug use absent harm – or substantial risk of harm, such as driving under the influence – to others. As long as 1.4 million people are arrested every year for nothing more than drug possession, drug cases will continue to flood the criminal justice system and cause unnecessary misery.

There has been increased discussion of late about courts that impose "swift and certain sanctions." This approach is premised on the belief that short periods of incarceration can reduce criminal recidivism. The HOPE Program in Hawaii[38] is an example of such a program. Because it appears that roughly one-third of HOPE participants are drug offenders, the program merits attention in this discussion of alternatives to incarceration for drug-involved offenders.

The HOPE program, however, has received publicity far more favorable than is warranted by the data published to date. Indeed, the data is quite thin and preliminary. But even if the HOPE program is shown to reduce criminal activity, it is far from clear that the outcomes achieved by the program in Hawaii are replicable with different populations and different criminal justice actors. Without careful safeguards (and perhaps even with them), it is likely that attempts to replicate HOPE will actually increase costs, jail stays and probation revocations for the most addicted participants. Indeed, HOPE-like programs have existed in various forms for thirty years but never have been taken successfully to scale.

Toward a Public Health Approach to Drug Use

Forty years after the United States embarked on a war on drugs, President Obama signed legislation in 2010 that promises to make drug treatment widely accessible within the mainstream health care system. This high-level political acknowledgement that drug use is fundamentally a health issue did not occur in a vacuum, but builds on the passage of the federal *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* and on the passage of similar bills in many states. The political development follows a social one, with national surveys revealing that a large majority of Americans believe that drug use is a health issue. Nevertheless, U.S. policy remains dominated by a punitive approach to drug use.

This legacy of punishment – and its inherent conflict with a health-centered approach – has persisted throughout the 20-year-old drug court experiment.

Drug courts have been an important experiment in reducing the harms associated with U.S. drug policies. Throughout the 1990s, people on the front lines of the drug war – primarily judges and prosecutors – came to understand that handing down long sentences for petty drug violations is as unjust as it is ineffective. Drug courts were developed in an attempt to develop more humane and effective interventions in the lives of people struggling with drug problems. Drug courts have undoubtedly helped many people find their way to a more stable and productive life outside of the criminal justice system.

On a policy level, however, drug courts have done little to mitigate – and in many instances may have aggravated – the harms associated with the mass-criminalization of people for illicit drug use and the failure to provide adequate and effective treatment to those who need and want it. The expansion of drug courts has helped create the myth that U.S. drug policy is more compassionate than it used to be and that help is available within the criminal justice system, even as the number of people incarcerated for drug possession continued to increase and funding for treatment in the community declined dramatically.

To create a successful health paradigm in the U.S., policymakers must end the criminalization of drug use, shift investments into public health programs that include harm reduction and treatment, and set health-oriented measures of success that focus on reducing the cumulative death, disease, crime and suffering associated with both drug use and drug prohibition. Our nation's drug policies should be evaluated – and funded – according to their ability to meet these goals.

Thank you for inviting me to testify before you today.

Endnotes

---

[1] Darren Urada, Angela Hawken, Bradley T. Conner, Elizabeth Evans, M. Douglas Anglin, Joy Yang, Cheryl Teruya, Diane Herbeck et al. *Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000: 2008 Report* (Los Angeles, CA: UCLA Integrated Substance Abuse Program, 2008), page 45

[2] California Department of Corrections and Rehabilitation. *Prison Census Data (December 2008)*. February 2009.

[3] Douglas Longshore, Angela Hawken, Darren Urada, M. Douglas Anglin, *Evaluation of the Substance Abuse and Crime Prevention Act: Cost-Analysis Report* (Los Angeles, CA: UCLA Integrated Substance Abuse Program, 2006).

[4] UCLA Evaluation 2008
[5] Longshore et al., *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report.*
[6] California Department of Alcohol and Drug Programs, "Proposition 36 Ballot Initiative (2000 General Election)," http://www.adp state.ca.us/SACPA/Proposition_36_text.shtml
[7] Longshore, Douglas et al, *Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report*, Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2004.
[8] California Department of Alcohol and Drug Programs and Judicial Council of California, Administrative Office of the Courts, *Drug Court Partnership Act of 1998, Chapter 1007, Statutes 1998 – Technical Report*, June 2002.
[9] Longshore et al., *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report.*
[10] Longshore et al., *SACPA Cost-Analysis Report (First and Second Years)*, Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2006.
[11] Ehlers, Scott and Jason Ziedenberg, *Proposition 36: Five Years Later*, Washington D.C.: Justice Policy Institute, April 2006.
[12] *See* "Drug Courts, Better DOJ Data Collection and Evaluation Efforts Needed to Measure Impact of Drug Court Programs," Government Accountability Office, April 2002 ("Despite a significant increase in the number of drug court programs . . . that are required to collect and maintain performance and outcome data, DOJ continues to lack vital information on the overall impact of federally funded drug court programs. . . [The public] lacks sufficient information to (1) measure long-term program benefits, if any; (2) assess the impact of federally funded drug court programs on the criminal behavior of substance abuse offenders; or (3) assess whether drug court programs are an effective use of federal funds." "As a result, DOJ cannot provide Congress, drug court stakeholders, and others with reliable information on the performance and impact of federally funded drug court programs.").
[13] Bhati et al., *To Treat or Not to Treat: Evidence on the Effects of Expanding Treatment to Drug-Involved Offenders.*
[14] U.S. Department of Justice, *Estimated Arrests For Drug Abuse Violations by Age Group, 1970-2007.*
[15] United States General Accounting Office, *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results from Other Outcomes*, Washington D.C.: GPO, February 2005.
[16] These drug court failure estimates are based on 1.4 million people who were arrested for drug possession in 2007. See U.S. Department of Justice, *Estimated Arrests for Drug Abuse Violations by Age Group, 1970-200.*
[17] See generally Boldt, "Rehabilitative Punishment and the Drug Treatment Court Movement"; Hoffman, "Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism"; Miller, "Embracing Addiction."
[18] Ibid.
[19] Bowers, "Contraindicated Drug Courts." Ethnographic descriptions of how this paradox manifests in practice are provided by study of a juvenile drug court in Whiteacre, Kevin, "Strange Bedfellows: The Tension of Coerced Treatment," *Criminal Justice Policy Review* 18, no. 3 (2007): 260-273: "staff members experienced personal ambivalence over the efficacy of sanctions as a therapeutic tool, particularly when faced with some juveniles' continued noncompliance despite the sanctions. Staff neutralized this tension by attributing noncompliance to the juveniles' lack of motivation, concluding coerced treatment only works for those who are "ready" for treatment. This would appear to pose a paradox for coerced treatment, which is meant to induce compliance specifically among those who are not motivated." See also Whiteacre, "Drug Court Justice."
[20] California Society of Addiction Medicine, "Proposition 36 Revisited," http://www.csam-asam.org/prop36article.vp.html; See also Goldkamp et al., "Do Drug Courts Work?"; Hepburn, John R., and Angela Harvey, "The Effect of the Threat of Legal Sanction on Program Retention and Completion: Is That Why They Stay in Drug Court?," *Crime and Delinquency* 53, no. 2 (2007): 255-280.
[21] Longshore et al., *SACPA Cost-Analysis Report (First and Second Years)*, Los Angeles, CA: UCLA Integrated Substance Abuse Programs 2006: 36 (citing Marlowe, D. B., and K. C. Kirby (1999). "Effective use of sanctions in drug courts: Lessons from behavioral research." National Drug Court Institute Review 2(1), 1–31)..
[22] De Leon et al., "The Role of Motivation and Readiness in Treatment and Recovery"; Hiller et al., "Motivation as a Predictor of Therapeutic Engagement in Mandated Residential Substance Abuse Treatment"; Joe, G.W., D.D. Simpson, and K.M. Broome, "Effects of Readiness for Drug Abuse Treatment on Client Retention and Assessment of Process," *Addiction* 93 (1998): 1177-1190; Simpson and Joe, "Motivation as a Predictor of Early Dropout from Drug Abuse Treatment."
[23] Hepburn, John R. and Angela Harvey, "The Effect of the Threat of Legal Sanction on Program Retention and Completion."
[24] Goldkamp et al., "Do Drug Courts Work?"

[25] Longshore, Douglas et al., *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report,* Los Angeles, CA: UCLA Substance Abuse Programs, 2007.
[26] Haney, Craig, "The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment," Paper presented at From Prison to Home: The Effect of Incarceration and Reentry on Children, Families and Communities, January 30-31, 2002, http://aspe.hhs.gov/hsp/prison2home02/haney.pdf.
[27] Deschenes et al., *An Experimental Evaluation of Drug Testing and Treatment Interventions for Probationers in Maricopa County, Arizona.*
[28] Rossman, Shelli Balter et al., "What Juvenile Drug Courts Do and How They Do It," in *Juvenile Drug Courts and Teen Substance Abuse,* eds. Jeffrey A. Butts, and John Roman (Washington D.C.: Urban Institute, 2004): 55-106.
[29] Hoffman, "Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism."
[30] Stevens, "Alternatives to What? Drug Treatment Alternatives as a Response to Prison Expansion and Overcrowding."
[31] Bhati et al., *To Treat or Not to Treat: Evidence on the Effects of Expanding Treatment to Drug-Involved Offenders*; Stevens, "Alternatives to What? Drug Treatment Alternatives as a Response to Prison Expansion and Overcrowding"; Pollack, Harold, Peter Reuter and Eric Sevigny, "If Drug Treatment Works So Well, Why Are So Many Drug Users in Prison?" http://www.nber.org/confer/2010/CRIs10/Reuter.pdf. See also Austin, James and Barry Krisberg, "The Unmet Promise of Alternatives to Incarceration," *Crime and Delinquency* 28, no. 3 (1982): 374-409.
[32] Stevens et al., "On Coercion"; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[33] Ibid.
[34] National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[35] Boldt, "Rehabilitative Punishment and the Drug Treatment Court Movement"; Miller, "Embracing Addiction"; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[36] Belenko, "Research on Drug Courts: A Critical Review"; Belenko, *Research on Drug Courts: A Critical Review (2001 Update)*; Fischer, B., "Doing Good with a Vengeance: A Critical Assessment of the Practices, Effects and Implications of Drug Treatment Courts in North America"; United States General Accounting Office, *Drug Courts: Overview of Growth, Characteristics, and Results;* United States General Accounting Office, *Drug Courts: Better DOJ Data Collections and Evaluation Efforts Needed to Measure Impact of Drug Court Programs;* King and Pasquarella, *Drug Courts: A Review of the Evidence*; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[37] *See* Ettner et al., "Benefit-Cost in the California Treatment Outcome Project;" Rydell, Peter C. and Susan S. Everingham, *Controlling Cocaine: Supply Versus Demand Programs,* Santa Monica, CA: RAND, 1994; Substance Abuse and Mental Health Services Administration, *The National Treatment Improvement Evaluation Study (NTIES), Final Report,* 1997.
[38] *See, e.g.* THE PEW CENTER ON THE STATES, THE IMPACT OF HAWAII'S HOPE PROGRAM ON DRUG USE, CRIME AND RECIDIVISM (January 2010).

Mr. KUCINICH. Thank you.
Ms. Heaps, you may proceed.

STATEMENT OF MELODY M. HEAPS

Ms. HEAPS. Thank you, Mr. Chairman. Thank you for this opportunity.

More than any other time in the history of American justice, we know what works and what doesn't when it comes to criminal justice and drug policy. We have moved beyond the platitudes of "get tough on crime" or "just say no." It is time for a change, and it is time to stop searching for that one silver bullet program and put in place what we know works all the way from arrest through incarceration through release.

I would like to discuss a concept called No Entry. It is not a new program, per se, but a new way of thinking about the administration of justice. It is an idea we have been discussing in Illinois with our legislature and with our representatives in Congress and particularly I want to acknowledge the leadership and support that we have had from Congressman Davis in these matters.

The core premise of No Entry is halting the penetration into or further into the justice system. Every phase of justice involvement, from arrest to jail to pre-trial to sentencing to release is an appropriate time for intervention, an opportunity for applying the best of what we know in science and best practice, sanctions and supervision, all with the explicit goal of preventing further or more severe justice involvement.

But No Entry is not an automatic or one size fits all approach. Rather, it is all about levying the appropriate response for the appropriate individual in the appropriate circumstances. And I want to acknowledge the work that Dr. Marlowe has done in terms of his sentencing and identifying of tiers of offenders and how good sentencing ought to be applied.

The TASC model, which I have had the privilege of leading over 40 years, is but one element of the No Entry approach. The TASC model emerged in the 1970's under LEAA, as an alternative to incarceration. The phrase used at that time is the phrase used now: it is time, after 40 years, we got serious and began to move ahead with this.

The TASC model involves the use of an independent case management entity to serve as a bridge between criminal justice and the treatment system. This entity provides independent assessment, diagnosis, treatment planning, referral and ongoing recovery management. TASC serves every court in the State of Illinois, every criminal court. Last year we conducted 6,700 clinical assessments and referred 3,800 individuals to treatment.

TASC takes great pride in our effectiveness. Last year, in 2009, two thirds or 64 percent of all of our clients completed treatment successfully, compared to only 33 percent of other criminally involved referred clients.

Additionally, client arrests for drug and property crimes were reduced by 71 percent. TASC is obviously cost-effective. The cost for TASC in treatment is $5,000 per year. The cost of 1 year of incarceration is $24,000.

Over the years, I have worked to expand the TASC model from its original court and probation role into other components of the Illinois justice system, all the way from diversion at the first offenders program that works much like project HOPE, and whose data and success rate is equal, to jail treatment programs, to reentry programs. So it is across the spectrum.

Our basic philosophy hasn't changed in 40 years. What has changed is how much we know about what works. Decades of research have changed the way drug treatment is applied to criminal justice populations. We understand the brain chemistry and the chronicity of addiction like never before. We understand the overlap between substance abuse and mental health.

We understand that episodic acute care in a treatment setting must be followed by long-term recovery management in the community. And we understand that new medications are developed every year that hold out tremendous promise for treating addiction. We know what cognitive and behavioral therapies and case management strategies can be applied and are most effective.

So what can Congress do to encourage States to put in place everything we know about effective drug and justice policy? I have some recommendations. No. 1, I would like us to begin to treat this as a system-level issue that will require the development of diversion programs or treatment alternatives at every juncture of the justice system, thereby requiring a multiplicity of partners and programs. There is no one silver bullet program. I want to reiterate that.

The response should be nuanced as to the jurisdictions in which they are applied. We have an array of proven initiatives. Certainly drug courts is one of them. Project HOPE looks promising. There are a number of them. But they all require and all include certain basic elements, which can be applied across the justice system.

Addressing alternatives to incarceration on a systems level means we need to bring the response to scale. We need to invest enough resources that have significant impact on the numbers of offenders coming through. Even in Illinois and in TASC in Cook County, we were only able to assess 2,700 people. But we know that the Cook County jail houses 9,000 individuals every year, half of which have a serious drug problem. So bringing it, while we have the infrastructure that could bring it to scale, the resources are obviously not there.

Second, I think Congress should consider mechanisms to fund demonstration programs that apply a systemic approach. These programs would be charged with developing the infrastructure and service capacity to intervene with as many justice-involved individuals effectively and efficiently. They would leverage and expand, leverage and expand, and improve existing programs and partnerships such as drug courts, TASC programs and other offender management programs. They should also be rigorously evaluated for their effectiveness.

Congress must also use the Justice block grant fund, and I know you talked about this early, to incentivize States to develop programs for prison crowding. Obviously, the Council of State Governments and the Justice Department reinvestment strategy is one way to do that. Those States demonstrating a reduction in popu-

lations and cost offsets applied to expanding community treatment should be eligible for a different formula for calculating and expanding future year block grant funding.

Third, I think we need to require the National Institute of Drug Abuse to continue to prioritize research and the discovery of effective interventions for persons with substance use disorders. And further ensure, and I think this is really important, that NIDA support efforts to translate that research to practice by supporting initiatives such as they do now called the Addiction Technology Transfer Center and blended conferences, bringing researchers and practitioners together.

Further, we need to prepare for the impact national health care will have on making treatment available for all offenders now not eligible for treatment. The advent of universal eligibility represents a fundamental shift in treatment funding and will likely result in new partners and new types and modes of treatment. It will definitely result in new levels of planning and coordination.

Finally, I want to commend the Office of National Drug Control Policy on their support for interagency work and planning through their interagency work groups. I also want to encourage that there be more experiences of blending funding between agencies, Justice, SAMHSA, etc., so that supports some of the demonstration on other programs.

And last, what is not in my testimony, I would be remiss if I did not say it is time that Congress stopped legislating according to the latest drug du jour. It is not the drug du jour that is the problem. There will be a new drug available to Americans to take their hearts and minds and souls every year, every month. What we need to do is look at the issue of addiction and what works in terms of helping that addiction as opposed to responding to the latest drug of choice.

Thank you, Mr. Chairman. Thank you. It is a pleasure to be here.

[The prepared statement of Ms. Heaps follows:]

Committee on Oversight and Government Reform

Testimony of Melody M. Heaps
President Emeritus, TASC Inc.
July 22, 2010

Mr. Chairman, members of the committee, thank you for the opportunity to testify before you today. My name is Melody Heaps, and I'm the President Emeritus of TASC, Inc., headquartered in Chicago, Illinois. For almost 40 years, I've worked with local, state and national policymakers seeking practical answers to the complex challenges of drug use and its impact on public safety and our criminal justice system.

More than any other time in the history of American justice, we know what works and what doesn't in criminal justice and drug policy. We've moved beyond the platitudes of "tough on crime" and "just say no" and now have decades of research, science and practice to underlay a shift that *needs* to take place in the way we think about justice and rehabilitation. We incarcerate 1 out of 100 Americans, a rate far higher than Russia, China and Iran. Our states spend 44 billion dollars every year on corrections - one out of every 15 public dollars spent in state budgets. It's time for a change. It's time to stop searching for a silver bullet program and put in place what we know works.

I'd like to discuss a concept called "No Entry". It's not a new program per se, but a new way of thinking about the administration of justice. It's an idea we've been discussing in Illinois and with our members of Congress. The core premise of No Entry is halting the penetration of offenders *into* or *further into* the justice system. Every phase of justice involvement, from arrest to jail to pretrial to sentencing to release, is an opportunity for intervention...an opportunity for applying the best of what we know in science, practice, sanctions and supervision, all with the explicit goal of preventing further or more severe justice involvement. Forty years of direct service has shown us the devastating cumulative effect of justice involvement. The further you go into the system, the more difficult it is restore your life to health and stability, and subsequently the more likely you are to find yourself back in front of a judge or in prison.

But No Entry is not an automatic or a one-size-fits-all approach. Rather it's all about levying the *appropriate* response for the *appropriate* individual in the *appropriate* circumstances. So to be successful, No Entry requires the justice system and the treatment system working in partnership to *assess* the needs of individual offenders and *place* them in a treatment plan appropriate for their clinical need and level of supervision.

The TASC Model

TASC is but one element of a No Entry approach. The TASC model emerged in the early 70s out of the Law Enforcement Assistance Administration as part of a funding stream dedicated to addressing what was then the *emerging* link between drug use and crime. TASC was a precursor to the modern drug court movement. The phrase used at the time was "treatment alternatives to incarceration" and here we are 40 years later again talking about alternatives to incarceration.

The TASC model involves the use of an independent case management entity to serve as a bridge between the criminal justice system and the community substance abuse treatment system. A clinical expert works with the court to identify defendants whose criminal behavior is linked to their drug use. That expert then conducts a comprehensive assessment to determine the nature and scope of the defendant's addiction, and makes a recommendation to the court as to an appropriate course of treatment. The judge balances the likelihood of success in treatment with the nature of the crime and the defendant's criminal history and decides on an appropriate sentence.

If the judge determines that the circumstances warrant treatment, the defendant is sentenced to probation, with intensive supervision by a clinical case manager. This case manager works with the offender to access the necessary type of treatment, along with other services that circumstances may dictate, such as mental health treatment, employment services, family counseling, and so forth. The case manager also reports to and works with the probation officer and the judge to ensure that the offender is

complying with the terms of their sentence, and whether or not an increase or decrease in the level of supervision may be warranted.

The independence of the case manager is central to the TASC model, as it brings an objective clinical perspective, balancing the mandates and priorities of both the treatment process and the criminal justice system.

Originally, the TASC model was employed as a demonstration project in Cook County, which includes Chicago. Based on the success of that demonstration, the Illinois General Assembly passed legislation and licensure regulations to institutionalize the model statewide, and agreed to assume the funding for the independent case management service, which led to the creation of TASC, Inc. in its current form.

Currently TASC serves every court in Illinois with a standard array of assessment, linkage and case management services. By law, every drug-involved offender who comes through the court system is de facto eligible for treatment as an alternative to incarceration, however the state has wisely placed limits on eligibility based on the nature of the crime and the defendant's criminal history.

Central to our operations is our accountability to our partners through reporting and constant communication. We're accountable to our justice partners for ensuring that offenders comply with their justice mandates. We're accountable to state treatment oversight for providing accessed to proven, licensed services in the community. And we're accountable to the people we serve, helping them navigate the array of social services and agencies to get them back on the path to health and stability.

Last year, TASC was responsible for conducting almost 6,700 clinical assessments statewide in its adult court-related programs, and was responsible for placing 3,800 individuals into treatment across Illinois.

Over the years we've worked to expand the TASC model from its original court and probation role into other components of the Illinois justice system. We worked with the Cook County Jail to address jail crowding by developing a Day Reporting model that significantly improved participation and court appearance rates. We worked with the Cook County State's Attorney's Office to develop a prosecutorial diversion program for first time offenders that provides drug education to over 3,000 individuals every year. We worked with the Illinois Association of Drug Court Professionals when they first drafted legislation empowering the creation of drug courts in Illinois. And we worked with the Illinois Department of Corrections to establish one of its prisons as a dedicated treatment and reentry-planning facility.

For your reference, I think it is important to distinguish the TASC model from other models you may know. There are some similarities between TASC and Proposition 36 in California, but the most significant *difference* is that TASC in Illinois is not mandated. Rather the decision to sentence someone to TASC supervision comes only after careful consideration of the defendant's clinical need and the judge's discretion in considering all of the circumstances.

There are also similarities between TASC and drug courts, and in fact Illinois operates a number of local drug courts in which TASC has a role. However, there are two points of distinction between TASC and drug courts. First is the independent case manager making clinical determinations and recommendations. Second is the statewide, *systemwide* scope of TASC, which effectively renders every court a drug court, but with centralized record keeping and access to a broader array of services.

In addition to our direct service, we've worked extensively with federal agencies like the Substance Abuse and Mental Health Services Administration, the Department of Justice, the Drug Enforcement Administration, the National Institutes on Drug Abuse, and the Office of National Drug Control Policy to pursue criminal justice strategies and policies that are both *just* and *effective* in reducing recidivism and improving public safety. We've

also provided consultation to states like Hawaii, Ohio, North Carolina, Arizona and California as they have wrestled with the growing burden of drug use and crime.

We Know What Works

Our basic philosophy hasn't changed in 40 years, what *has* changed is how much we know about what works. Decades of research have changed the way drug treatment is applied to the criminal justice population. We understand the brain chemistry and the chronicity of addiction like never before. We understand the overlap between substance abuse and mental health. We understand that acute, episodic care must be matched with long-term recovery management. We understand that medication-assisted treatment holds tremendous promise for opiate-involved populations. We know what cognitive and behavioral therapies and case management strategies are most effective.

We know these things because of the continual work by agencies like the Substance Abuse and Mental Health Services Administration and the National Institutes on Drug Abuse to emphasize data collection and accountability. We're accountable to agencies that fund us, our justice partners, and the public we serve to *make our communities more safe.* In 2009, we looked at our outcomes compared to outcomes for other criminal justice and treatment clients as reported by the Department of Health and Human Services. What we found is that two thirds (64%) of TASC clients complete treatment successfully, compared to only one third (33%) of all criminal justice-referred clients in Illinois, and only a quarter (27%) of non-criminal justice participants in treatment. Completion of treatment is one of the key determining factors in the reduction of drug use and criminal behavior. Compared to before they came to TASC, client arrests for drug and property crimes were reduced by 71%.

Accountability also includes efficiency. In Illinois the cost of one year of treatment and TASC supervision is roughly $5,000. The cost of one year of incarceration is $24,000.

I'll say it again: we know what works. We know how to improve community safety while improving recovery prospects for individuals and while prudently using public resources. Let's move forward.

Challenges Remain

Many states have made the connection between drug use, crime and treatment on a practical level, and have engaged programs ranging from TASC to specialty courts to Breaking the Cycle to reentry. And yet we still find ourselves caught in a logic gap at the highest levels of state policymaking.

I mentioned a moment ago the $19,000 cost difference between TASC supervision and incarceration. Coupled with the dramatic difference in long-term prospects for drug use and recidivism, this seems to be a financial no-brainer, and yet this year saw near double-digit cuts in TASC's state contract and in overall funding for treatment while the Governor sought to cut corrections spending through the early release of prisoners. Sadly, this represents a *good* year for treatment in Illinois.

Recommendations

And so the question is "What can Congress do to finally break through this barrier and encourage states to put in place everything we know about effective drug and justice policy?" I have several recommendations I'd like to present for the Committee's consideration:

First, we need to **treat this as a systems-level issue** that will require the development of diversion programs or treatment alternatives at every juncture of the justice system, thereby requiring a multiplicity of partners and programs. *There is no silver bullet.* The responses should be as nuanced as the jurisdictions in which they're applied. We have an array of proven initiatives, evidence-based practices, and promising practices at our disposal, including drug courts and other specialty courts, intensive case management like TASC, medication-assisted treatment, and dozens of others. These tools need to be

applied as appropriate for each jurisdiction, their needs, and what programs may already exist.

I spoke about the notion of every court being a drug court. That's the mentality we need to have if we want to break the self-perpetuating cycle of drugs and crime and truly begin to realize cost savings and improved public safety. Decades of program-level responses have contributed to disparities in access to alternatives, which in turn have led to disparities in justice involvement by minorities. These disparities are cumulative in nature, devastating minority communities by normalizing justice involvement within a community and across generations.

Addressing alternatives to incarceration on a systems level means we need to bring the response to scale. We need to invest enough resources to have a significant impact on the numbers of offenders coming through our justice systems. TASC in Illinois is statutorily available to tens of thousands of offenders each year. However, because TASC and the treatment services to which it refers are tied to limited state contracts, we can only provide a limited number of services. The judges know this. The prosecuting attorneys know this. And so we only see a referral stream that is a fraction of the total possible population we could serve. For example, in Cook County, TASC received only 2,773 referrals in all of 2009 from our court programs, despite a county jail with an average *daily* population over 9,000 that turns over many times over the course of a year. There is no doubt in my mind that if we had twice as many case managers, we would have twice the number of clients. The need is that great.

We need to get past the situation we experience yearly in Illinois, where treatment is cut under the guise of "cost savings", despite consistent evidence that money invested in treatment reduces the cost of line items like criminal justice and healthcare several times over. Justice practitioners need to know that individuals mandated to treatment alternatives will get access to timely, quality treatment. Without it, the justice system simply won't trust treatment as a viable response.

My second recommendation is that Congress consider mechanisms to **fund demonstration programs that apply a systemic approach** to justice policy. These demonstration programs would be charged with developing the infrastructure and service capacity to intervene with as many justice-involved individuals as effectively and efficiently as possible. They would leverage, expand and improve *existing* programs and partnerships, such as drug courts, TASC programs, and similar offender management programs where they exist. They would require the justice systems to analyze the nature of the offenders coming into the system, the treatment and other resources available in the community, and gaps in justice alternatives. They would also be rigorously evaluated for effectiveness over time.

Congress can also use the existing Justice Block Grant to incentivize states to develop programs that specifically reduce jail and prison crowding. Those states demonstrating reduction in populations and cost offsets applied to expanding community treatment would be eligible for a different formula for calculating and expanding future years block grant funding. The Council of State Government's Justice Reinvestment strategy has paved the way for a cost offset approach, using data and economics to inform the effective application of resources.

My third recommendation is that we **require the National Institutes on Drug Abuse to continue to prioritize research in the discovery of effective interventions** for persons with substance use disorders in the justice system, and further ensure that NIDA support efforts to translate that research into practice by supporting initiatives like the Addiction Technology Transfer Centers and blended conferences, bringing researches and clinicians together.

Fourth, we need to **prepare for the impact that national health care will have on making treatment services available to persons with substance use disorders under criminal justice supervision.** The advent of universal eligibility represents a fundamental shift in treatment funding, likely resulting in new partners and new types or modes of treatment. It will *definitely* result in new levels of planning, coordination,

communication, and information exchange between justice and treatment systems. Now is the time to consider specialty managed care functions specific to drug-involved justice populations and to equip states to build the infrastructure that will allow them to fully leverage this new source of funding.

Finally, I want to commend the Office of National Drug Control Policy for organizing interagency working groups with SAMHSA, the Department of Justice, and others, to review their ongoing programs and initiatives. Congress should encourage the continuance of this activity and **require demonstrations of blended funding programs dedicated to expanding alternatives and treatment interventions**.

Ladies and Gentlemen of this Subcommittee, the time is now. We need to move aggressively to take advantage of all of the factors working in our favor. I commend the Subcommittee for its work, and appreciate the opportunity to testify today.

Mr. KUCINICH. Thank you, Ms. Heaps.

Professor Pollack, you are recognized.

STATEMENT OF HAROLD A. POLLACK

Mr. POLLACK. Thank you very much, Mr. Chairman. I also would like to acknowledge Representative Davis' wonderful work, particularly on behalf of injection drug users in Illinois.

I would like to emphasize several points today, many of which have come up before. First, drug courts and other diversion programs help many individuals and are highly cost-effective and require more resources. These programs cannot as currently operated be expected to much reduce the prison population. This may seem counter intuitive, so let me say something about that. Many diversion programs are based on two completely correct premises. One is that treatment reduces drug use, and the second is that reducing drug use will reduce crime.

Interventions channel drug-using offenders into treatment and for the individuals involved, these interventions are very important and effective. So expanding these programs is something that deserves high priority.

When we think about this at the population level, however, we see these programs have basic limitations, which helps to explain why the proliferation of drug courts and other diversion programs has not slowed the incarceration of drug users. As noted in our accompanying materials and as has been talked about by several previous witnesses, the number of Americans incarcerated every year for drug offenses has increased since 1980. In our data, the number of prisoners with drug problems markedly increased over the past 20 years, despite the fact that in many ways the overall drug use population is actually going down, at least when we look at heroin, cocaine and methamphetamine.

So what is going on here? There are three obstacles that really require attention. The first of which we have discussed already is that the overall capacity of drug courts is quite limited. Drug courts handle about 55,000 offenders per year. To put this in context, there are about a million drug-involved offenders that pass through the criminal justice system every year. So as several witnesses have discussed, the value of something like HOPE as a front-end intervention would be very important. But we have to somehow address that obstacle.

Second, drug courts do serve a relatively low-risk population, rather than the much larger criminally active groups that are the ones that actually determine the prison population. Only 12 percent of drug courts accept clients with prior violent convictions. Individuals facing drug selling charges, even if the seller is drug-dependent, are often excluded. Other charges that routinely lead people to be excluded include theft, fraud, prostitution, domestic violence.

We find in our own statistical work that the typical drug court eligibility requirements would exclude about 70 percent of newly sentenced offenders who present with heroin, cocaine or methamphetamine disorders. So many of the offenders who are eligible for drug courts are really not the people who are contributing numerically to the prison population right now.

So as currently operated, drug courts help many, many specific individuals. But they can't really be expected to reduce the prison population unless we expand the categories of individuals that these interventions will serve.

And this brings us to the third issue that we talk about, which is the systematic mismatch between sentencing practices and actual criminal careers of drug-involved offenders. And this is very much the evidence-based sentencing set of issues that have been talked about before. Between 1986 and 2004, the median age of newly admitted inmates with cocaine disorders increased by 8 years, from 26 years old to 34 years old. We see similar, although somewhat less dramatic patterns for other substances. We actually don't see the same aging of the population for prisoners who don't have drug disorders.

Why is that important? As drug users get older, they are treated increasingly harshly for each successive offense. And they become less eligible for a lot of the diversion programs that we have. Many of these individuals have long criminal careers that include property crime, failed drug tests and violations that might land them back in prison. They are progressively more likely to get harsh sentences even as we know they are progressively less likely to actually be violent and to commit violent crimes.

We examined prison data from the year 2004, and we compared young drug-involved offenders to old drug-involved offenders. What we found was that drug users under the age of 25 were twice as likely to have committed a violent crime, but they were much less likely to be labeled habitual offenders or to face sentencing enhancements.

So if we want to prevent violence, policymakers need to explore alternative mechanisms, alternative sentencing policies and post-release policies that match the dangers that offenders are posing. And really, we think there are two different populations that deserve attention.

One is we need to explore the expansion and improvement of intensive programs for young drug users. These are by far the most violent segment of the drug-using population. They are difficult clients to serve. Judging by the standard clinical criteria, programs are going to look bad if they really focus on this population. They often achieve poor treatment outcomes. They can be difficult clients for a lot of programs. The crime control benefits of serving this population are very great.

Two final thoughts. One is that offenders' everyday experiences in programs is what is really decisive in determining whether programs are effective. And I very much agree with the sentiment expressed, we spent a lot of time looking for a breakthrough program model or theoretical perspective. The quality of how programs are implemented is really much more important. And if you say, what is special about HOPE, what is special about a lot of interventions, they are done well. And that is really important.

Offenders learn very quickly from their daily experience whether a program is going to respond predictively, swiftly, and credibly, either to the violations or to their positive behavior. If the program responds quickly, you can influence offenders. If it doesn't, you very quickly lose the ability to be effective in behavior changes. So I

think John Roman's work certainly speaks to many of these issues very well.

Finally, we lack strong data to evaluate the most common or the most promising interventions. I think it is true that drug courts are the most carefully studied interventions we have in the area. Even so, recent systematic reviews identify only four studies that use random assignments that really reach perspective to help us. We need to do more rigorous intervention trials, particularly ones that explore how we can serve offenders who are unlikely to participate or who are unlikely to be permitted to participate in our traditional efforts.

Focusing on the young offenders who need more intensive services and the older offenders who are less violent are really two areas that we need to emphasize. We do need to expand drug courts to serve people who are not currently being served. It won't be easy, and an evidence-approach to it is quite important.

Thank you very much, and I would be happy to answer your questions.

[The prepared statement of Mr. Pollack follows:]

Prepared testimony of Harold A. Pollack before the Domestic Policy Subcommittee of the House Committee on Oversight and Government Reform, July 22, 2010.

ALTERNATIVES TO INCARCERATION FOR DRUG-INVOLVED OFFENDERS

Mr. Chairman:

Thank you for the opportunity to speak today. I should state that my testimony represents my personal views, not those of any colleague, organization, or funder. With your permission, I would like to place into the record a paper I co-produced with Peter Reuter and Eric Sevigny that provides technical details to amplify my statement here.[1]

This is a portentous moment for both criminal justice and drug policy. We have a national drug strategy. Health reform and parity legislation are changing the financial landscape of substance abuse treatment and preventive services. State and local budget crises lead citizens to question policies that result in high incarceration rates with greater urgency. The same fiscal pressures are damaging a variety of services serving the criminal justice population. Growing attention paid to drug courts, interventions such as Hawaii HOPE, and ballot initiatives such as California's Proposition 36 reflect the widespread view that American drug policy has lost its way.

New approaches are surely needed. Crime rates have been relatively low for more than a decade. Major heroin and cocaine epidemics have ebbed. Yet we still incarcerate more people for drug offenses than Western Europe incarcerates for all crimes.[2] Offenders continue to enter prison with high rates of drug use disorders. We continue to see high rates of criminal activity and high rates of re-incarceration among recently-released offenders.

Across the political spectrum, Americans seek strategies to safely reduce the financial and human costs of incarcerating so many drug users and sellers. Available research underscores the difficulty, but also the necessity of this task. This will be hard, in part, because drug-involved offenders have longer and more serious criminal records than one might suppose. Yet many of these offenders are treated more harshly than is warranted by their likely future offending. Particularly if one's focus is on violent offenses, a better balance can be struck.

I would emphasize five points today.

1. Current drug courts and other diversion programs do much good for individuals and are cost-effective. They will not appreciably reduce the prison population because most drug-involved offenders are not eligible for them.
2. The population of drug-involved offenders is aging faster than other offending populations. As drug-users get older, they receive increasingly harsh sentences even as their violent offending declines.
3. Pre-sentencing diversion must be complemented by effective reentry programs to better help and monitor offenders in community settings.
4. Offenders' everyday experience will be the decisive factor in program effectiveness.
5. We lack strong data to evaluate the most common or the most promising interventions. Rigorous evaluation is therefore essential.

Drug courts and related diversion programs provide better help and monitoring for individual offenders. They do not—and probably cannot, as currently configured—markedly reduce the U.S. prison population.

An array of diversion programs have been fielded based on two well-documented premises: (a) Treatment can significantly reduce drug use, and (b) Reduced drug use produces marked reductions in crime. Interventions built on these two premises encourage or coerce drug-involved offenders into treatment. A large research literature shows that these interventions indeed reduce drug use and associated criminal activity and are highly cost-effective.[3, 4] Expanding and improving these programs deserves high policy priority.

Yet these programs, as currently configured, have inherent limitations. One must consider these limitations in evaluating some disappointing correctional trends. There has been little overall decline in the population of incarcerated drug users. Indeed, the number incarcerated for drug offenses has increased every year since 1980. As noted in the accompanying materials, the number of prisoners with drug problems markedly increased from 1986 to 2004.

These patterns are especially dismaying given the declining number of Americans who maintain costly use of heroin, cocaine, or methamphetamine over the past two decades. Why is it so hard to reduce the number of incarcerated drug-involved offenders? Focusing in particular on drug courts, why have these diversion efforts had such little numerical impact at the population level?

In my view, three obstacles must be noted:

First, *the overall capacity of such programs is limited.* The drug court movement is almost twenty years old. More than 2,300 separate programs have been created.[5] Yet only about 55,000 offenders are processed in such courts.[6] To put this in context, more than million drug-involved offenders enter the criminal justice system each year. Most jurisdictions lack the administrative capacity to implement drug courts at-scale.

Second, *these programs generally serve relatively low-risk populations rather than the (larger) high-risk populations most likely to experience the greatest net reduction in crime.* Bhati and colleagues report that "only 12% of drug courts accept clients with any prior violent convictions. Individuals facing a drug charge, even if the seller is drug-dependent, are excluded in 70% of courts for felony sales and 53% of courts for misdemeanor sales. Other charges that routinely lead to exclusion include property crimes commonly associated with drug use (theft, fraud, prostitution), and current domestic violence cases (only 20% accept domestic violence cases)."[6]

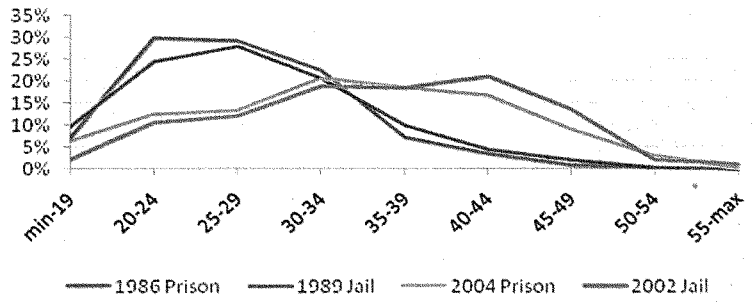
We find in our own statistical work that drug court eligibility requirements typically exclude 70 percent of newly-sentenced offenders with heroin, cocaine, or methamphetamine disorders. Many offenders who *do* participate in drug courts would receive relatively light sentences absent the intervention. Well-implemented drug courts can be quite effective for these participants. As currently configured, drug courts will not markedly reduce the prison population, which is disproportionately shaped by serious offenders who serve the longest sentences.

Third, *there is a systematic mismatch between sentencing practices and actual criminal careers among drug-involved offenders.* As criminally-active drug users get older, they are treated

increasingly harshly for each successive offense. They have longer criminal histories, longer records of unsuccessful treatment, and worse employment histories. Thus, not only are they less eligible for diversion programs, they also receive longer sentences.

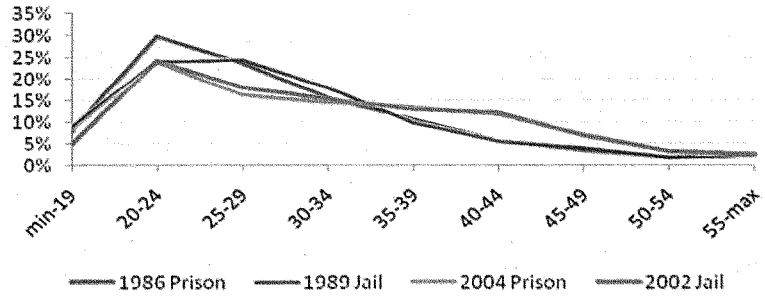
The population of drug-involved offenders is aging faster than other offending populations. Let me amplify that last point a bit. Below, I reprint Figure 7 from my joint paper with Reuter and Sevigny. It shows the age distribution of newly-incarcerated jail and prison inmates who

Figure 7. Age Distributions of Newly-Incarcerated Inmates Reporting Cocaine Abuse



indicated cocaine problems in the month before their arrest. Between 1986 and 2004, the median

Figure 9. Age Distributions of Newly-Incarcerated Inmates Reporting No Drug Abuse



age of newly-admitted prison inmates with cocaine disorders increased by almost eight years. (The change look even larger when one focuses on older ages, including the rapidly growing geriatric population.) We see similar (though less dramatic) patterns for heroin and methamphetamine. We find no similar upward age drift in the population of newly-incarcerated inmates who did not report drug problems. (See Figure 9.)

Older offenders are less likely to be violent, but are more likely to receive long sentences. These demographic patterns are especially important given the concentration of violent offending among younger offenders. Many drug-involved offenders have long criminal careers which include property crime, failed drug tests, and other violations of parole and probation requirements that create the risk of incarceration. They are therefore progressively more likely to be disqualified from diversion programs, even as their probability of violent offending declines.

Table 1 shows these patterns among newly-sentenced drug users in 2004 prison survey data. Compared with inmates over the age of 35, inmates younger than 25 were twice as likely to have committed a violent crime. Yet these young offenders were half as likely to be labeled habitual offenders or to face sentence enhancements for their current crime.

	Incoming state prison inmates younger than age 25			Incoming state prison inmates older than age 35		
Substance used within one month of incarceration	Probability of current offense being violent	Prob of "Habitual offender" label	Probability of sentence enhancement for current offense	Prob of current offense being violent	Prob of "Habitual offender" label	Prob of sentence enhancement for current offense
Cocaine	40%	7%	16%	16%	24%	37%
Methamphetamine	41%	5%	21%	18%	23%	32%
Heroin	42%	11%	11%	18%	38%	50%

If the goal of correctional policy is to prevent future violence, policymakers would be wise to explore alternative sentencing, diversion, and post-release monitoring policies for older offenders who have not committed recent violent offenses. For example, some commentators have proposed to "sunset" offenses after a defined period of non-offending.

We also should explore the expansion and improvement of intensive programs that for young drug users who are the most violent segment of the offending population. Using data from the National Treatment Improvement Evaluation Studies, Anirban Basu, David Paltiel, and I explored the economic value of drug treatment interventions in preventing armed robbery.[7] Judged by standard clinical criteria, young drug-involved offenders achieved relatively poor treatment outcomes. These were difficult clients. Yet the economic and social benefits of treatment were very large for young offenders, because even highly imperfect treatment prevented many armed robberies in this criminally active group.

Pre-sentencing diversion must be complemented by effective reentry programs to better help and monitor offenders in community settings.
Given the above findings, "front end" diversion programs should be complemented by improved interventions to address the large population of offenders on parole and probation. These individuals display high rates of re-offending. Research by Stephen Raphael indicates that the annual re-incarceration rate for typical parolees in 2005 was more than double the rate observed in 1980. Numerical simulations indicate that reducing these re-incarceration rates to 1980 levels

would reduce the long-term incarcerated population by more than 20 percent.[8] Improved supervision of individuals who are already in community settings may also prove more politically sustainable than early release or pre-sentencing diversion.

This committee is discussing the impressive results from Hawaii HOPE. Compared with a control group, probationers assigned to HOPE were significantly less likely to produce positive drug tests or to be arrested over a 12-month study period. They were less likely to miss probation appointments. Although these offenders received more intensive and intrusive monitoring, they spent many fewer days in prison due to revocations or new convictions. HOPE and similar interventions seem especially promising for people who satisfy criteria for substance abuse who are not actually dependent; and for those who would otherwise lack access to effective treatment.

For opiate-dependent offenders, strengthening immediate linkages into post-release methadone maintenance also appears promising. Similar linkages of drug-involved offenders into long-term residential treatment and therapeutic communities are also associated with reduced reoffending. Within-prison treatment is valuable. Yet the small existing literature suggests that the benefit is quickly lost without prompt linkages into services upon release. A remarkable *New England Journal of Medicine* study by Binswanger and colleagues[9] documented a large spike in overdose mortality within the first two weeks post-release. Many of these overdoses occur before ex-offenders receive a single social or medical service. Addressing these service gaps remains a key challenge.

Offenders' everyday experience will be decisive in determining program effectiveness. Researchers and policymakers often search for some breakthrough program model or theoretical perspective in making better interventions. Studies of many behavior change interventions suggest that the quality of implementation is no less important. Offenders quickly learn from their everyday experience whether programs respond predictably, swiftly, and credibly to their behavior. If the program does not, one's ability to change behavior through incentives and sanctions quickly erodes. HOPE appears successful, in large part because it is well-implemented and includes a passionate champion committed to its success. The same principles apply to other behavior change interventions. Understanding the impact of specific components of drug courts and other diversion programs remains a key challenge.

We lack strong data to evaluate the most common or the most promising interventions. Strong evaluations are therefore essential.
The published literature includes hundreds of evaluations. Drug courts are probably the best-studied of these interventions. Only a handful of true experiments have occurred even with these interventions. Recent systematic review identified only four studies that had used random assignment; two of these experienced high attrition rates.[10] As noted above, we need better interventions that serve two particular populations: young offenders who require better help and monitoring to protect public safety, and older offenders we may no longer need to lock up.

More generally, we need to perform rigorous intervention trials which serve offenders unlikely to participate or to be deemed eligible for traditional diversion efforts. Expanding the scope of current efforts will not be easy. It is essential to reach the main populations of drug-involved offenders. Federal support is essential to undertake this effort.

Sources

1. Pollack HA, Reuter P, Sevigny E. If drug treatment works so well, why are so many drug users in prison? In: Cook PJ, Ludwig J, eds. *NBER Economic Crime Control Conference*. University of California at Berkeley; 2010.
2. Caulkins JP, Chandler S. Long-Run Trends in Incarceration of Drug Offenders in the US. *Crime and Delinquency* 2006;52(4):619-641.
3. Prendergast ML, Podus D, Chang E. Program factors and treatment outcomes in drug dependence treatment: An examination using meta-analysis. *Substance Use & Misuse* 2000;35(12-14):1931-1965.
4. Prendergast ML, Podus D, Chang E, Urada D. The effectiveness of drug abuse treatment: a meta-analysis of comparison group studies. *Drug and Alcohol Dependence* 2002;67(1):53-72.
5. Anonymous. Summary of Drug Court Activity by State and County. July 14, 2009. In. Washington, DC: BJA Drug Court Clearinghouse Project at American University; 2009.
6. Bhati A, Roman J, Chalfin A. To Treat or Not to Treat: Evidence on the Effects of Expanding Treatment to Drug-Involved Offenders. In. Washington, DC: Urban Institute; 2008.
7. Basu A, Paltiel AD, Pollack HA. Social costs of robbery and the cost-effectiveness of substance abuse treatment. *Health Economics* 2008;17(8):927-946.
8. Raphael S. Improving Employment Prospects for Former Prison Inmates: Challenges and Policy. In: Cook PJ, Ludwig J, eds. *NBER Economic Crime Control Conference*. University of California at Berkeley; 2010.
9. Binswanger IA. Release from prison - A high risk of death for former inmates (vol 356, pg 157, 2007). *New England Journal of Medicine* 2007;356(5):536-536.
10. Wilson D, Mitchell O, MacKenzie D. A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology* 2006;2:459-487.

Mr. KUCINICH. Thank you to each and every one of you for your testimony. As I said, having reviewed the fullness of your testimony, I felt very constrained to interrupt any of you. I know that some of you were as brief as you could possibly be. I appreciate your help with that. I honor your work and your presence here.

We held a hearing last month where the ONDCP Deputy Director, Dr. McLellan, and the NIDA had explored the theme of treating drug addiction as a disease. What I would like to hear from each member of the panel, describe for me the tension between the operation of any programs that we are discussing here with the idea of criminal punishment for continuing to use drugs or suffering from chronic relapsing conditions. Underpinning that, assumptions of whether individuals have control over that at all. I would like to hear from you.

So let's start with Professor Pollack and go right down the line. Just give me your thoughts about that.

Mr. POLLACK. Well, there are gradations of drug use that are important to think about. But it is something that we need to approach as a public health concern. And one of the——

Mr. KUCINICH. As a disease? As a health condition?

Mr. POLLACK. Certainly, for people who are dependent, it is a disease. Also, many diseases that we treat have behavioral components that have common elements with substance use. If you look at diabetes, diabetes has a substantial behavioral component to it. When people eat candy bars when they're diabetic, we don't kick them out of the diabetic clinic. We need to understand, many diseases have the kind of psychological and behavioral dimensions that we deal with in substance abuse as well.

Mr. KUCINICH. Ms. Heaps.

Ms. HEAPS. I understand there is a tension. It always amazes me that we don't seem to understand that they are not mutually exclusive. We do know that now addiction, beyond a reasonable doubt, is a brain disease and it is chronic. There are consequences to not complying with treatment. And if that——

Mr. KUCINICH. You are saying addiction is a brain disease based on neuroscience research?

Ms. HEAPS. Based on the neuroscience and all that we have seen. It has been, I think, one of the most remarkable advances in treatment by coming to really understand that.

However, there are consequences to not complying with treatment. And if that non-compliance means that individuals have engaged in a criminal activity which is at harm in the community, they need to pay those consequences. We know very much that consequences are important in terms of helping individuals comply. Therefore, there has to be an understanding.

Now, does that mean if an individual is in, has complied with treatment and has a relapse in the community and is using drugs and all of a sudden we yank them back and send them back to prison? Not necessarily. It is certainly possible that we can look at that person, assess the level of treatment they are getting, assess where they are, and like any other disease, suggest perhaps a new treatment intervention, a new increase in dosage, etc. I think we have to be able to blend more carefully what we know about inter-

ventions with regard to chronic disease models and recovery in the community.

Mr. KUCINICH. Mr. Abrahamson.

Mr. ABRAHAMSON. [Remarks off mic.] There is no question that there should be criminal justice involvement. And that the rule for treatment within the criminal justice system is an important one and must be provided consistent with evidence-based proven principles of how to provide that treatment.

There is a fundamental tension, however, when dealing with drug use in and of itself where there is no harm to others or property. And there is a fundamental tension in using the criminal justice system to assess and to address that type of drug use. I believe that fundamental tension of incorporating the criminal justice system in those circumstances actually serves to undermine core principles of treatment, to weaken treatment and distort how treatment is delivered, and that treatment ought to be delivered to those persons who should not be involved in the criminal justice system in community-based settings.

And that their relapse on drugs, as discussed earlier, as a common condition of being addicted, should not be addressed through punitive sanctions.

Mr. MARLOWE. Any concept, over-applied, will fail. Addiction is a brain disease except when it isn't. People require punishment except when they don't. And they require treatment except when they don't.

In other words, there isn't one type of drug-involved offender. Most drug-involved offenders do not suffer the brain damage that we are referring to as addiction, when they have exposed their brain repeatedly to a toxin and changed the neurochemistry of their brain in many respects permanently. Most offenders are not, in fact, addicts. So treatment——

Mr. KUCINICH. Most offenders are not in fact what?

Mr. MARLOWE. Addicts. Most offenders, drug-involved offenders, are abusing, using drugs but have not damaged their brain sufficiently. So we need to make a distinction between the abusing offenders and the addicted offenders.

We then need to make a distinction between the antisocial offenders and the non-antisocial offender. If somebody is addicted and antisocial, they need both treatment and criminal justice monitoring. If they are addicted and not antisocial, treatment in and of itself would be an appropriate disposition. If they are antisocial and not addicted, the criminal justice system in its traditional manner would be the appropriate disposition. And if they are neither addicted nor antisocial, we should divert them out as quickly as possible.

In other words, if we come up with a policy that overapplies one concept to a heterogeneous population, we will keep making the same mistakes over and over again.

Mr. KUCINICH. Is that what we are doing?

Mr. MARLOWE. That is what we are doing. No question about it. It is a pendulum and you can watch it go back and forth. I can predict where the conversation will go over the next 10 years. Right now we are going toward diverting out, primarily because of the extensive correctional costs, legalizing people are out pushing for non-

consequences. We are going to be moving more toward a public health model in and of itself. Crime rates will go up. Violence rates will go up.

Don't you believe for 1 second that the drug problem is going down in this country. It may be that there is less crack cocaine and methamphetamine. We now see oxycodone, Vicodin, it is just changing the face. If we don't do both, hold people accountable and provide treatment when it is necessary, we will be 10 years from now talking about the failed rehabilitation efforts and the need to reincarcerate, because we have been there five times before and we will be there five times again.

Mr. KUCINICH. Mr. Roman, and then I have a followup question to everybody on the panel after Professor Hawken responds.

Mr. ROMAN. Let me try and say something that hasn't been said. I would really caution against minimizing how much criminal activity surrounds drug trade and drug use. The correctional system, the courts, the law enforcement——

Mr. KUCINICH. Is anyone here minimizing it?

Mr. ROMAN. There are suggestions that a lot of the people who are getting into drug courts in particular aren't people who have any serious criminal involvement. That is true, because we exclude the people with serious criminal involvement from drug courts. But the population that we would like to have into drug court, if you expand it in the ways that I sort of discussed earlier, would be people who have involvement in serious criminal activity. So to that extent, the courts do seem an appropriate place to work with them.

That is more true now for two reasons. One is that the courts are more and more integrating public health principles. We talked about drug courts today, but there are all sorts of alternatives.

Mr. KUCINICH. Those principles being?

Mr. ROMAN. The sort of principles of including therapeutic jurisprudence, this sort of idea that relapse is part of recovery, that you don't just the first time somebody relapses, you don't just send them back to prison, you give them sanctions, the graduated sanctions model. It has really begun to permeate the criminal justice system. I think I am more optimistic than Doug that we can continue to head in that direction and that we should.

And the other thing is really just from a purely practical perspective, our research really suggests that coercion works. The main thing that we see in our drug court study that predicts how well a drug court works, not practices, but the court itself, is how well the judge, how effective the judge is at communicating to the defendants in front of them, and that courts that really have good judges, good leadership, have the best results. Better than we have seen in the public health model.

Mr. KUCINICH. Professor Hawken, the question I have asked everyone to address is the overall question of treating drug addiction as a disease. I know that your background is very strong on policy analysis. So help us go in that direction. Give us your opinion on this.

Ms. HAWKEN. I think we had the example of diabetes earlier. If we had a group of 100 diabetics and we looked them in the eye tonight and we said, if you wake up tomorrow with diabetes, you are

going to jail. Well, tomorrow morning all 100 of those diabetics are going to continue to be diabetic.

If we did the same thing with 100 drug offenders, tomorrow morning only 20 of them are going to be drug offenders. Eighty percent of them are not. That's what the Hawaii data are showing us.

The problem we have is figuring out who is that 20 and who is that 80. Who is the true addict and who is just misbehaving? Because we don't want to spend our treatment resources on those who are just misbehaving.

This is the issue, we have very weak mechanisms of deciding who is in which camp. Primarily we rely on assessments of these drug offenders, and the assessments rely heavily on self-report. Now, if you have ever met a drug offender, you will know these guys are not stupid. These are very smart individuals. If you tell them, they know very quickly that certain kinds of responses will lead to different kinds of consequences. So if I exaggerate my drug use, I am likely to get a treatment referral rather than a jail stay. The incentive is to exaggerate.

Or if they know that if they under-report their drug use, they are more likely to get into a less intensive treatment program, well, today they are going to under-report. They lie. And we have very compelling evidence, as David Farady's research has shown, a 70 percent disconnect between what they say and what their hair says they have been doing. My research shows a 50 percent disconnect. In other words, we know nothing from what they tell us.

So we are in a pickle. If we could brain scan all of them and see the brain damage, we would know who goes where. But that is too expensive. We need programs like HOPE, and it doesn't have to be HOPE, HOPE is one, we need to experiment with others, but that can very quickly help us identify who belongs where, who is the true addict and who can be managed inexpensively by just looking over their shoulder more closely.

Mr. KUCINICH. You raise a question. Is there a Munchausen syndrome amongst addicts, people just making up the degree of use?

Ms. HAWKEN. Well, misreporting, there is an incentive to misreport your drug use if there is an outcome you know that you can change. And there ultimately is, there's a decision about what will happen with you within the criminal justice system, or there is a decision that can be made by someone else about where you will end up in the drug treatment system. Those are consequences, so you can game. It is a gaming problem.

Mr. KUCINICH. Mr. Marlowe, I saw you shaking your head there.

Mr. MARLOWE. The problem with addicts is not over-reporting. The problem with addicts is under-reporting. Munchausen syndrome is so that you can gain positive attention. Since addicts don't get positive attention in our society, it is never the part of a Munchausen syndrome. The issue is to be able to identify the person who is minimizing their drug use, who really has an addiction problem. And the way you do it is you talk to their mother, or you talk to their father, or their friends. And you will know immediately who the addicts are and who the non-addicts are, because their behavior is fundamentally different.

If you are only going to ask them, hey, Mr. Chairman, are you an addict or not, and rely on your answer, then you are right, we

are going to do a lousy job. But if I talk to the people who know you, I will know. And if I look at your record and your background and treatment, I will know very reliably whether or not you are an addict.

Mr. KUCINICH. Which gets into the second question I wanted to ask each member for a brief response. Are there predictors, social predictors, of who becomes an addict and who does not? And the more fundamental question, which I try to ask of everyone who testifies in front of this committee, if I have the chance to, what is this in our society or any society about this tremendous move toward addiction? What is it about, how does it happen? Certainly every one of you has a theory about what drives addiction generally to anything. But we are talking specifically about drugs that can have a very damaging effect on peoples' lives.

So if you would like to try a stab at that in any way, I would appreciate it, Professor Hawken.

Ms. HAWKEN. I don't think I can give a very good response to that. I don't really know. I think we have some evidence on genetic links. I think primarily the issue is drugs are very nice for most people. They take them and they enjoy them. And people want to do more of that.

I think in tough economic times, people want more of something really pleasant and will do it. I think it is very difficult to try to pinpoint one particular explanation for something as complex as drug use.

Mr. KUCINICH. I would like to hear some generalities at this point. Because we are having hearing after hearing on this matter, our subcommittee is charged with the responsibility to review these policies. But what we are doing is trying to get some fundamentals, even if it is speculative, I would like to hear it. Mr. Roman.

Mr. ROMAN. It is a very good question and one I wish I had thought more about. I think what we see in looking at the statistics about who comes into drug court, what you are seeing are people who have an enormous number of problems. There is a lot of co-occurring mental health disorders, since people are to some extent self-medicating. There are a lot of people who have personal lives that are in absolute disarray.

We looked at a study in Brooklyn, and I think the average woman who entered the Brooklyn treatment court had had four children and had custody of less than one. These are people who have, we see evidence that drug court increases income among people who get drug court. It increases it from like $12,000 a year to $13,000. So these are people who on average wouldn't even qualify to take a GED program.

So, people who have just enormous structural deficits in their lives are the population who tend to come into drug court. Doug and other people can talk better about this. But you look at other, you look at a DWI court when you are dealing with alcoholics and you are talking about, you would see people with a different set of predictors. But at least for drug court, that seems to be the story.

Mr. MARLOWE. It is a matter of Darwinian evolution. Drugs were developed because plants needed to control the behavior of insects and rodents in order to have their pollen spread, in order to avoid predators. So they created chemicals that are meant to speak to

our brains in ways that we like our brains spoken to, in ways that are fundamentally rewarding and eventually make you sick if you stop taking them.

So plants that are addictive were created through eons of evolution to do exactly what they are doing. We are wired to want to feel good. We like it when certain parts of our brains light up. And that is why the primary motivation for drug use is to do the happy dance that Professor Hawken was talking about. Then it switches to making the withdrawal symptoms and the cravings go away.

Now, the issue about the more broken the population the higher the rates, there are several things at work. One is downward drift. The more people use drugs, the less competent and effective they are, they get poor, they get sick and their families suffer and their offspring suffer as a result. So drug use leads to poverty as much as poverty leads to drug use.

In addition, the more pain and disorganization people experience, the more they want that to go away by replacing it with mood altering drugs. So there are many reasons why addiction is so rampant. But from a Darwinian perspective, we should wonder why it isn't more rampant than it in fact is.

Mr. KUCINICH. Let me ask you, since you have this background in psychiatry, if a mother or a pregnant woman, rather, is an addict, is it more likely that the fetus, development of the fetal brain will have the kind of hard-wiring characteristics that you talk about that creates a greater propensity toward addiction for that fetus?

Mr. MARLOWE. Yes and no. If a first degree relative is an addict, you have a 50 percent greater likelihood of developing addiction. That is because of genetic vulnerability.

Mr. KUCINICH. We are talking about addiction, we could be talking about any kind of addiction, alcohol, drugs, anything.

Mr. MARLOWE. Correct. As Melody made the point earlier, the drug of abuse really isn't that relevant. All drugs of abuse work on the brain pretty much the same way. Some are dirtier than others, but they are triggering the same brain regions that cause reward. That is basically what is going on.

The mother who is using drugs is passing on two problems to her child. Actually three problems to her child. One, she has a genetic vulnerability that just because it is her child, her child will have. Two, she is modeling misbehavior for that child by using drugs during that child's growing up years. So the child has a genetic vulnerability and is witnessing the bad behavior.

Third, the in utero exposure to drugs of abuse damages the brain, no question about it, including marijuana, cigarettes, particularly alcohol. So that fetus, when it is born, is now less capable of functioning well in society. So now it has a genetic vulnerability, bad modeling from mom and dad, and it can't function as well as his friends and other colleagues. So it is a triple threat. You do not want a mommy or a daddy using drugs. It is the last thing in the world you want.

Mr. KUCINICH. Mr. Abrahamson.

Mr. ABRAHAMSON. Mr. Chairman, I don't have the background to speak to the social predictors of who uses drugs or who becomes addicted. But I can speak to the social predictors of who uses drugs

and becomes an offender within the criminal justice system. I think the leading social predictor for that is poverty, lack of resources.

For people with means, for people with money, people who can afford drug treatment in the community, those people do whatever they can to keep themselves, their family members, out of the criminal justice system and to provide substance abuse treatment when it appears that such treatment is needed. We have resorted to using the criminal justice system for providing treatment to those without means. So we have essentially a two-tiered system.

I think the recent reforms in health care, which seek to assure that private insurance provides insurance for substance abuse treatment on par with other medical conditions is an important background fact for this entire discussion that places substance abuse and addiction squarely within the health sector. And it is for the people without means that we resort to the criminal justice system to provide what ought to be provided in the community. Thank you.

Mr. KUCINICH. Ms. Heaps.

Ms. HEAPS. It is a wonderful question, Mr. Chairman. We take drugs because we want to feel better, we want to relax, we want to get energy, any thousand reasons why we take drugs in this country. And I am so glad we are talking about alcohol. We have to understand that our fascination with alcohol in this country is generations and centuries old.

There is a new book out called The Last Call, and I recommend it to everybody. The Last Call. It has actually gotten quite good reviews, and it really is looking at alcohol, its policy over the last two centuries. It is an amazing discussion of how we have come from women who were WCTU individuals, because their families were being broken up because of the degree of alcoholism, and the United States, when we were awash with alcoholics, to the amendment which absolutely said we couldn't drink at all to where we are today.

So there are reasons why we either sensationalize drug and alcohol use and make it a Hollywoodesque approach. Or we are embarrassed by it, and say, oh, we don't want to be purists, we don't want to be WCTU, we are going to put it in the closet. Or we say, medical marijuana seems to be OK, and we don't put the rigorous test of what that means and how it is dispensed in the same way we do other medications for illnesses.

It seems to me, until we come up with a public health approach to drug use and addiction, just as we did to cigarette use, until we get messages out that, yes, taking drugs is really maybe a potentially dangerous, dangerous game, and you need to understand the consequences of it, you need to understand the effects of it. It needs to be on the media. We need to approach it just like we did cigarette use.

I think until we get to that place in our society, we are not going to be able to tackle this problem. It is in some ways an infectious disease. The more you see people use it, the more they seem to be excited by it, the more, the kids in high school are trying it and getting high and isn't that fun, and a little bit here and a little bit there. But we don't know what their genetic deficiencies are. We

don't understand when that initial poor judgment on drug use is going to trip into perhaps a more serious abuse and even addiction.

So I really do think we need to take a real look at our drug policy and start to very seriously say, drug use has consequences, and Americans, we need to know what those consequences are. It is and can be a very devastating disease.

Mr. KUCINICH. Professor Pollack.

Mr. POLLACK. I want to make a general comment and a specific comment about prenatal substance use, which you mentioned. I think as a general comment, the use of intoxicating substances is really very deeply embedded in our culture and our economy. I think the alcohol issue is so profound in every area of public health and public policy. It is striking, actually, I realized at some point I knew very little about marijuana. I had done all this public health and criminal justice research, and for most of the issues that I studied, alcohol was so critical and marijuana was a little bit less critical, although it is also a significant issue. But alcohol just comes up so often.

When people use intoxicating substances, they sometimes lead to problems in their lives. You go to college, you drink a lot at parties and you graduate, and then you realized you can't get hung over and go to work the next morning. Most people have cues in their lives that allow them to stop using at that point, or to reduce the use so it is not harmful. Some people, either due to genetics or because of their life circumstances are such that they don't generate sufficiently powerful ways to control that use, and they have use disorders. Those are the people that end up in our treatment.

But I think there is a much broader issue about how do we reduce or control things like alcohol that are just out there, normative, tobacco another one.

On prenatal substance use, I think the most serious issues that we need to focus on are really two-fold. One is, for most of these substances, the most serious biological issue is that they are going to increase how much mom uses alcohol. One of the ironies in the cocaine debate was that biologically, the cocaine wasn't all that harmful to the fetuses. But these moms were doing a lot of alcohol use and other things during pregnancy that were embedded in the cocaine use that created an issue.

The second issue of course is, it is really hard to take care of your baby if you have a drug use disorder. And a lot of these infants are quite healthy when they are born. But then the question comes in, how do we take care of that child. So we have to be very careful, one of the ironies in the cocaine debate was, we really stigmatized a lot of these infants as biologically damaged. But the real damage was pediatric, it wasn't obstetric. It was, how do you take care of this basically physically healthy baby if mom has a cocaine disorder.

So I think that there are changes to the brain in utero and so on. But we have to be a little bit careful about that. Because the real issue is just who is going to take care of this child after that child is born. Most of these kids are quite capable of leading very healthy lives if they are raised with the resources and the nurturing that they deserve.

Mr. MARLOWE. I am sorry, I can't let that go unchallenged. There were a lot of assumptions about crack babies and all kinds of terrible things that were going to happen that didn't occur. So therefore, everybody has breathed a sigh of relief and said that there is no damage.

I can assure you, Mr. Chairman, you would not be the chairman of this committee if your mother was smoking marijuana or using cocaine when you were in utero. Because you would probably on average be about 5 to 6 IQ points lower. And that 5 to 6 IQ points would make you much less adaptive to the world as it is.

Mr. KUCINICH. Given that I am a Member of Congress, I am not going to comment on that. [Laughter.]

But I appreciate your generosity.

Mr. MARLOWE. The point is that we are seeing that the disruption occurs after fourth grade, probably sometimes closer to fifth, sixth, seventh grade. Disinhibition, lack of attention, lower IQ. There is no question about it.

Mr. KUCINICH. There is a lot of research available in the Journal of Endocrinology and other places where, if a pregnant woman consumes a lot of alcohol, the potential for, for example, the neuroendocrine system to be adversely affected is possible. There are some studies that would suggest that.

I know that Professor Hawken has a plane to catch. And if you are flying out of BWI, based on my experience, if your flight is at 8 o'clock, this would be a perfect time for you to leave. Is there anything that you wanted to add before you are excused? And if there is anybody else that has any flight arrangements that would require that you leave right now.

Ms. HAWKEN. I do have one final comment, and I would like to thank you for mentioning one of the recommendations that I never made it to today. That was the use and abuse of evidence-based practices and how weak our evidence base really is.

But the last recommendation I would implore you to take seriously as I fly out of the room, quite literally, is to try to encourage truly independent evaluation. To grow this research field, we really have to do more good research. I am saying this because I was an evaluator of Proposition 36. And the State agency that was being evaluated under Prop 36 also oversaw the evaluation.

We really have to make sure we have truly independent evaluations and try to find some way of separating the task of evaluation from the organization that is being evaluated. That is something that happens all the time, and we are never going to improve the field. The evaluations that came out of those studies where the evaluated is being evaluated are always much higher. They never look bad, because they control the dissemination of information, which is not good for the field at all.

Mr. KUCINICH. I appreciate your testimony and the subcommittee will be in touch with you regarding some followup questions that we have.

Ms. HAWKEN. Good. Thank you very much for your time.

Mr. KUCINICH. For the rest of the panel, if you could just remain for a few more minutes, because I have a number of other questions, if you have the time. Why don't we just agree that no matter what, by a quarter after 6, can all of you stay until then? And I

know there are people in the audience who have to go and have been very patient. It has been a long day here already.

I want to go to Dr. Marlowe and Dr. Roman. Both of you support the expansion of drug courts to enroll offenders with more serious drug abuse problems and criminal histories. However, it appears that drug court clients in these populations may have different needs, and hence that drug court operations must also change to meet them.

What does the research have to say about the effectiveness of the current drug court model in meeting the needs of these offenders? And does more research need to be conducted on the issue? You can answer that now that Professor Hawken is gone. [Laughter.]

Mr. MARLOWE. The drug court model was built for the high risk addicted offender in mind. That is what the 10 key components was built for. The weak link in drug court practice is treatment. That is where the weakness is. Many drug courts can only draw from outpatient programs that have a handful of hours a week to provide service. You need to be filling 40 to 70 percent of a high-risk addicted offender's time with treatment and vocational and other services. That is really where the biggest weak link is. Probation is already suited to the job. The judiciary is already suited to the job. It is in the clinical services.

Mr. ROMAN. I would just add to that, I think one of the things that I see when I go to drug courts is that I think they don't take the, one of the things people always say about drug courts is if you have seen one drug court you have seen one drug court. And they are all different. When we did our study, we got 23 drug courts and they are all over the map in terms of outcomes. There is very little standardization. NDCI has done a terrific job trying to provide training to try and get drug courts to read from the same sheet of music. I think they have been effective, but there is a long way to go there.

One of the things that we find is that the sanctioning model that comes out of HOPE is the sanctioning model that comes out of drug court. It gets applied very haphazardly in drug courts in a lot of places. If you are going to work with a more serious population that is of higher risk to the public from being treated in the community rather than being incarcerated, then you have to take very seriously the piece of drug court that is most effective at managing their behavior. That is graduated sanctions.

So the one thing that I advocate is that we need to start saying, we find these great pieces of research like what Doug found with the relationship between high-risk offenders and the judge. Then what we have to do is set up some sort of mechanism that credentials drug courts that use those best practices. It has two advantages. One is that it is an easy place to go for them to get information about what works.

The second thing is, we don't have to continue to say, wow, we need to do more drug court evaluation. All we need to do is for you to demonstrate that you adhere to best practices. Then when you go to your county commissioners for additional funding, you don't have to pull out a drug court evaluation. You just say, I have this, I have been accredited, I have been certified, whatever the thing is.

Mr. MARLOWE. I second that. That is exactly what we need to do.

Mr. KUCINICH. Professor Pollack, in a paper you co-authored, you report that you find the fact that only one third of Prop 36 clients completed treatment, encouraging given comparative outcomes from other criminal justice referrals, and the fact that the sanctions for not completing treatment were not severe. Some point to this one third number as a disappointment and a prime motivating factor to the failed attempt to modify the program.

Why should this be considered a success? I would also like to have Mr. Abrahamson reply to that.

Mr. POLLACK. Others here know more than I do about Prop 36. I would say, if I were to design an optimal public policy, I would have a more, I would have a deeper infrastructure than they have been able to establish in Prop 36. Clearly, there is a significant management challenge of that number of people and how do we really sort through it, as Angela discussed, how do we really sort through it to find the appropriate people.

Given some of the shortcomings of the program, when I look at the outcomes, they are not bad. There were a lot of people who were effectively served through Proposition 36, even though it was not a particularly, it was a policy that was not implemented in the way that drug courts over time can be done.

If you look at traditional treatment programs, a lot of people don't finish treatment in all the treatment modalities. So we have to take that one-third number and keep it in some perspective.

I will let others comment.

Mr. KUCINICH. Mr. Abrahamson, do you want to comment on that?

Mr. ABRAHAMSON. Yes, thank you, Mr. Chair.

The one-third figure, three comments. First, the one-third figure of successful completion of treatment in Prop 36 is on par with the completion rates in drug courts and other criminal justice interventions and the UCLA study says as much. Now, there is a separate, slightly different issue also involving the term one-third or one-fourth which is the no show rate of people who agreed to participate in Prop 36 but never showed up to treatment.

Now, that no-show rate, there are three points to that. First, again, that would be on par with the data that we have for other criminal justice interventions of who agrees at first to accept that intervention and doesn't show up. But the second, more important point is, when that figure was published by UCLA, counties around California stood up and said, that just doesn't resonate with us. Our experience with Prop 36 was quite different.

So they went back and they looked at the data that UCLA had used about the no-shows. And they discovered a couple of things. First, that no-show data included people who, after accepting Prop 36 treatment, changed their minds and said, no, sentence me to the traditional incarceration term that I would be subject to without diversion. That number also included people who had pending court actions and who were rendered ineligible for Prop 36 because they had another court case in the system.

That no-show figure also included people who participated in drug treatment programs not funded by the counties, namely veterans, who received treatment through the VA system, and persons

with money who could pay for their own treatment outside of the county system. Those people went to treatment, completed treatment but were listed as no-shows in the data.

When the data for L.A. County was recalibrated to take account of each of those categories, the no-shows dropped from 45 percent in 2001 to 6.7 percent. And for 2002–2003, the no-show rates dropped from 35 percent to 2.6 percent. Those are critical drops. So I would suggest that the data that was published on that issue was deeply flawed.

One last comment. Prop 36 has not and likely will not meet its full potential, providing adequate treatment to people in the system. By the law's own terms, people are to be assessed according to their treatment needs and placed in the appropriate treatment. So a person who is not addicted to drugs should not be receiving traditional drug treatment through Prop 36. And those that are deeply addicted and need inpatient treatment should receive that.

That promise has not been met in Prop 36 for the chief reason that starting in 2005, Prop 36 became dramatically underfunded. According to the legislative analyst's office and the Little Hoover Commission in California, adequate treatment funding for Prop 36 should be set at 2008 levels of $220 million a year. Instead, in 2007, Prop 36 was cut from $120 million to $100 million. And last year it was cut to $30 million. And this year, funding for Prop 36 might be cut altogether.

And so that is the situation we find ourselves in. Thank you.

Mr. POLLACK. Could I just quickly add that the State and local budget crisis is so fundamental to everything we are talking about. I get the sense that drug policy, we have health reform coming in 2014 in a big way. And until 2014, we are really going to struggle, because States and localities just do not have the funds to do services. And substance abuse and mental health services are precisely the kinds of things that are getting very deep budget cuts all over the country.

I think we actually all have a really strong degree of consensus about a lot of the programs that need to be done. I think these are just not going to be funded at the level that they need to be funded, particularly as stimulus funds run out. The budget crisis in Illinois, California and many other States is just killing a lot of programs that have a strong evidence base. That hasn't come explicitly today, but it is fundamental.

Mr. KUCINICH. One of the things that I noted in Ms. Heaps' testimony, which really went the distance toward addressing some of these underlying economic issues, where I think you had talked about preparing for the impact national health care will have on making treatment services available, I think that you really spoke directly to a mechanism that could change everything as far as, if we are talking about a public health crisis here, if we are talking about a disease-based approach to drug abuse, at least for the ones who aren't socially regressive patients, then I think your testimony was right on.

Mr. HEAPS. Thank you, Mr. Chairman. Yes, I absolutely believe it will be a fundamental shift, with one modification. With all the promise of national health care, and therefore the eligibility of individuals who essentially are offenders, not eligible for Medicaid, etc.,

and not eligible therefore for a significant funding stream for treatment. When that becomes available, it still has to be integrated into the justice system. And the fact that we don't yet, have not put in place the right infrastructure to help make that available is really, really critical.

So one of the challenges for national health care policy is to look at how that will be delivered to people who are under the jurisdiction of the system, so that the courts and other members of that system have access to the services for those individuals. That infrastructure needs to be put in place. Whether we call it specialty managed care——

Mr. KUCINICH. As the person who with John Conyers actually wrote the bill, H.R. 676, I took note of what you said, and I take further note of your comments now about fitting that particular population into the program. It is very well taken and it could be a fundamental part of trying to get real care delivered for people who have this difficulty.

I am going to ask each one of you to just give me a kind of a wrap-up statement about the direction you would like to see us go in. But before we do that, I was struck by the response of Dr. Marlowe, when you were talking, I had asked the question, why do people do this, why do people go for drugs. You gave a very learned response with respect to Darwinian evolution. This is where, as chairman, my staff gives me a whole list of questions. Occasionally somebody says something and it gets me thinking and I may not have a chance to ask this question again.

If you on one hand, a philosophical output of Darwinian evolution is determinism. On the other hand, there has been a lot of research in the last few decades on concepts that deal with brain plasticity. A principle of evolutionary biology which is called punctuated equilibrium, where the species develops very quickly and rapidly, breaking out of a linear progression, going kind of into an upward spiral.

My question to you is, do you foresee, is there a potential, based on your research and understanding of psychiatry, the science of the brain, that human beings have the capability of evolving beyond this desire for this level of gratification? Or is this just where we are?

Mr. MARLOWE. That sounds like a term paper I might have assigned to my graduate students. [Laughter.]

It is actually a very good question. Because I didn't mean to suggest, although I am a Skinnerian behaviorist by background, if you couldn't figure that out, I didn't mean to suggest that the seeking of pleasure and dispelling pain are the be all and end all of human behavior and cognition. We are capable already of higher aspirations than that. We are capable of not engaging in immediate pleasure for greater good that doesn't actually come back to us. We have now proven altruism exists.

Mr. KUCINICH. This is important to hear this. I will tell you why. Because there are a number of Members of Congress that when we talk about the kinds of challenges that people face, whether it is alcoholism or hard drug abuse, they will cite the value of faith-based initiatives. And I understand that. And I understand the

idea of the human spirit having the potential to actually leap over a whole series of consequences and transform.

Mr. MARLOWE. Right.

Mr. KUCINICH. Would you comment on that? Because I want to make sure that those who have been watching this, and it does go to a Webcast, aren't left with the idea that we are just hard-wired.

Mr. MARLOWE. There are many roads to recovery. I think this is the best way I can answer the question. There are people who never get that spark. The people from the 12-step community call it a spark where they just all of a sudden, there is a realization, there is something they feel that they have touched and they are different people. Thank God for the people who experience that spark. Where it comes from, I can't answer. I don't know if it is biochemical or spiritual, I don't know.

I also know that there are a lot of people who got better and didn't experience anything remotely resembling a spark for 20 or 30 years after sobriety. So if you are saying that everybody has to have a spark to get better, you are going to be damning a lot of people to terrible pain. On the other hand, if you discount this faith-based community and these faith-based principles, you are also going to be damning a lot of people to pain.

Mr. KUCINICH. So there are variable factors on the road to recovery?

Mr. MARLOWE. Exactly. I think that is right.

Mr. KUCINICH. And you wouldn't discount any of them?

Mr. MARLOWE. Absolutely. Just talk to people from AA. You will hear something very powerful.

Mr. KUCINICH. I appreciate your taking a moment so that we could engage in a colloquy about that.

Why don't we start with Professor Pollack. If you would just, based on your career and your research, if there is anything you would like to put on the record as a closing comment that would guide the deliberation of this committee on national drug policy.

Mr. POLLACK. I think that all of us today expressed many common elements of what needs to be done. What I would like to see is a real focus on being evidence-based, providing the resources to do it, and really paying careful attention to the public management and implementation challenges that need to be addressed to do it well. I think that is going to be fundamental in our success.

Ms. HEAPS. Let me build on that statement. I concur completely. We have to look at the total justice system, from arrest all the way through parole. At every point, there is an opportunity of intervention which builds exactly on what Professor Pollack talked about, with appropriate interventions, appropriate evidence-based practices. There is no silver bullet program. Every court should have elements of a drug court. Every criminal court ought to be able to refer people into treatment and have available to them assessment diagnosis, court reporting and compliance issues.

So there has to be a systemic approach in which we can bring to scale the numbers of people who are being put into various levels of intervention or acute treatment, so that we really grasp and get at the issue of reducing the numbers of people who are addicted or using drugs or under some level of influence by drugs and there-

fore reduce the impact on the justice system and the cost to our communities.

Mr. KUCINICH. Mr. Abrahamson.

Mr. ABRAHAMSON. My focus for today's hearing would be simply that the criminal justice system cannot adequately address the needs of the 1.4 million people arrested every year for simple drug possession. We need to focus on when those people first come into contact with the criminal justice system, typically a police officer on the beat. That we figure out a way to keep people who have used drugs and may have a drug problem, but have not caused harm to other individuals, how to keep them out of the criminal justice system and provide the services or treatment that they need in the community, and then use the criminal justice system to deal with the offenders who actually deserve to be in the criminal justice system. Thank you.

Mr. MARLOWE. I would just reiterate what we have already said, which is that we need to move away from programs to systems, and to continuum in the criminal justice system. We actually do know what the elements of an effective system would look like. We have just never ever done it. And I think that Melody's idea about moving pilot funding toward system development is exactly on the money. I always turn to Melody Heaps for the policy implications of science, because she knows how to make that translation.

But the reality is, we can't put everyone in drug court, nor should we. We can't put everybody in project HOPE. We can't put everybody in Prop 36. We need something like a TASC model of assessment, placement, monitoring at the systemic level. I think we are there. I think the time has come to do that.

Mr. ROMAN. Four points in 30 seconds. One way to do that is to start talking about reducing crime in drug use and stop talking about recidivism. Talking about recidivism makes us think small. If you want to do something about drug policy and reduce crime, you have to talk about it in those terms.

Second, we have to start standardizing practice. The do anything you want anywhere thing, we know too much to keep doing that. We don't want to stifle innovation, but we have to start getting drug courts and these other alternatives to incarceration programs to implement best practices that we know exist. We have to start doing something HOPE-like, because of the budget pressures that the States are under. We have to start finding cheap solutions to these problems. What HOPE does is it makes the defendant signal to the court how they are going to do. What could be cheaper than that?

Then finally, what we do when we do those things is to take the money that we would have spent on those people in the court system, in the processing and take it off the table and redirect it to more expensive things like drug court. Because if we just wait for the end of the day for project HOPE to leave money in the budget, it won't be there and we will never be able to use it. We have to do it up front.

Thank you for having me testify.

Mr. KUCINICH. Your last point is very well taken in this era of cost-consciousness. It is actually cost-effective, as you are pointing out, by far.

I am very grateful to each member of this panel and to Dr. Hawken as well as to our first set of panelists for the time that you spent here today. What I am going to ask my staff to do is to gather this transcript, to take your testimony and gather this transcript as quickly as possible and to see if we can find a means of editing it for publication and getting it distributed as quickly as possible to Members of Congress and the community beyond. The papers that you delivered to the committee were very important. You have absolutely proven the urgency of your testimony to this committee. Each of you has experience which is quite valid in the larger sphere of drug policy, its effectiveness or lack thereof.

So the subcommittee staff will continue to be in touch with you.

I want to thank the minority staff for their presence and for the participation of Mr. Jordan as well as our own staff of the majority for helping to schedule this hearing.

This is the Domestic Policy Subcommittee of Oversight and Government Reform. I am Dennis Kucinich, Chairman of the subcommittee. Today we have talked about Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders. We have had a distinguished list of witnesses.

This subcommittee will continue to reserve jurisdiction over all matters affecting the Office of National Drug Control Policy and drug control policy generally. We will do so, gratefully with the assistance of our panelists. I want to thank, again, each and every one of you.

This subcommittee stands adjourned.

[Whereupon, at 6:18 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON DOMESTIC POLICY

July 22, 2010 Hearing On:

Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders

Post-Hearing Submission by Daniel N. Abrahamson, Director of Legal Affairs, Drug Policy Alliance, Co-Author, Proposition 36.

This submission is in response to a claim made by Professor Angela Hawken, in her written and oral testimony, and echoed by Representative Watson at the hearing, that "one quarter of the offenders who agreed to California's Proposition 36 never appeared for treatment." This claim was one of the key arguments made by Professor Hawken as to why Proposition 36, as an alternative to incarceration, was "disappointing." The fact that the data does not appear to support Dr. Hawken's claim is therefore worthy of clarification. As explained below, the one-quarter "no show rate" figure appears to be grossly exaggerated as a result of poor or improper data collection by counties. The actual "no show" rate for Prop. 36 offenders may well be nearer to 2-5%.

The data regarding treatment "no shows" for offenders who agreed to participate in Prop. 36 were published by the University of California Los Angeles (UCLA). This data garnered substantial attention among Prop. 36 stakeholders and was the subject of state legislative hearings and media commentary. It was generally assumed by critics of Prop. 36 that the "no show" data revealed a serious problem of persons ignoring or reneging on their commitment to enter treatment as a condition of probation under Prop. 36.

Rich and detailed data from the largest county in California, Los Angeles County – whose residents represent over 20% of the entire Prop. 36 population – indicate, however, that systemic gaps in data collection at the county level are more likely to be at fault and that it is wrong to assume that most of the so-called "no shows" absconded from a program in which they agreed to participate.

To determine "show" rates, UCLA used two sets of data: one from court rooms to determine how many people were sentenced to Prop. 36 probation and treatment; the other from state- and county-funded drug treatment facilities to determine how many people entered treatment. In their analysis of "show rates", UCLA simply subtracted the treatment facilities' data from the court data and determined that the remainder represented people who accepted Prop 36 sentencing but did not enter treatment. In reality, however, the processes for entering Prop. 36 are not so simple.

A parsing of L.A. County data shows that many people who were counted in the court room as having accepted Prop. 36 were not then counted at a treatment facility quite simply because they were *not expected* to end up in county-provided Prop. 36 drug treatment programs. Many persons who initially accepted Prop. 36 treatment voluntarily withdrew from the program and, with full notice given to the court, accepted conventional sentencing instead. Other persons had pending court actions at the time they agreed to Prop. 36 that subsequently disqualified them from Prop. 36 or prevented them from participating in the program. (Both of these groups show up in court data as having entered Prop. 36, however.) Still other persons accepted Prop 36 in the court but were not counted in the treatment facility data because they chose to enroll in alternative treatment programs, such as drug court, Veterans Affairs programs or privately-funded treatment. Finally, some offenders were erroneously listed as "no shows" for still different reasons *other than* the fact that they had silently reneged, absconded or otherwise disappeared without court approval.

With respect to alternative substance abuse treatment programs, the Los Angeles County data show that the 5-6% of county Prop. 36 participants – those who had attended privately-paid treatment programs, mental health programs, Veterans Affairs treatment programs, or drug courts – were counted by UCLA researchers as "no shows" despite the fact these persons entered treatment as a direct result of Prop. 36!

In L.A. County, by far the largest drop in numbers between referral to Prop. 36 and assessment for Prop. 36 treatment, or between assessment for treatment and commencement of treatment, appears to comprise persons who expressly "declined participation" in Prop. 36 and opted for traditional sentencing though they initially declared an intent to enroll in Prop. 36. Importantly, these persons' subsequent change of mind occurred with notice to the court and with acceptance of conventional sentencing. UCLA data, however, strangely catalogue persons who resigned from Prop. 36 in order to face traditional punishment as "no shows."

The voluntary withdrawal from Prop. 36 by a large percentage of Los Angeles County offenders is not particularly surprising. UCLA's 2003 report on Prop. 36 notes that 91% of eligible offenders who refused Prop. 36 diversion at the outset accepted "routine criminal justice processing" (2003 report, p. 28). This 2003 finding foreshadows the Los Angeles data that the majority of people who openly and voluntarily resigned from Prop. 36 before commencing treatment simply exercised their statutory right to decline participation in the program. UCLA researchers, however, never acknowledged this dynamic and reported these persons as "no shows".

Remarkably, if one takes the data L.A. County has published showing all the reasons people drop out of the Prop. 36 data set, recalculating "no-show" rates based only on those classified as "no-shows," dismissals, or those found unamenable to their treatment programs, the county's overall "no-show" rate drops dramatically – to **6.7%** instead of 45% for 2001-02, for instance, and to **2.6%** instead of 35.1% for 2002-03.

Close inspection of Los Angeles County Prop. 36 data strongly suggest that UCLA's statewide data lack crucial detail and nuance that could dramatically change, even reverse, perceptions of the so-called "no-show" issue. (At a minimum, it is certain that L.A. County's data have skewed the statewide figures regarding "no shows": the number of "no shows" coming out of L.A. County alone represented between 15% and 30% of the statewide total number of "no shows" in various years of data collection.) Could the true "no-show" figure statewide – the number who truly renege and are lost to the courts and probation – be closer to 3% or 7% than to 30%? The L.A. County data indicate that this could be the case.

In light of the serious questions about the integrity of the data published by UCLA regarding "no shows," UCLA researchers were asked by several stakeholders to conduct a separate study focusing just on the issue of "no-shows." This request, however, coincided with severe cuts in funding to Prop. 36 programs by the State of California which, in turn, eliminated funding for further Prop. 36 research by state-funded institutions. As a result, the "no show" data has not been revisited or revised and so continue to convey an inaccurate and unreasonably negative picture with regard to the issue of "no shows." Thanks to L.A. County's more fine-tuned data collection, however, the problems of UCLA's "no show" rates are openly acknowledged in Prop. 36 policy circles in California.

It is critical for policymakers to have accurate data on which to base their analysis. Thus, this letter has focused on a particularly glaring data problem. However, this sub-debate should not overshadow the larger and equally important discussion about how best to increase treatment engagement, compliance and completion – not just in Prop. 36 but across the board in drug treatment and probation. In its annual reports to the state, UCLA has repeatedly outlined effective and affordable strategies for further improvements in treatment engagement and compliance. The Drug Policy Alliance supports those recommendations, including co-locating services and providing transportation, child care and case management. All of these approaches have been demonstrated to increase the number of people who enter and who stay in treatment. Like with other chronic health conditions – including diabetes and hypertension – physicians and treatment specialists are always working to improve treatment compliance rates.

○