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DRUG TREATMENT OPTIONS FOR THE JUSTICE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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DRUG TREATMENT OPTIONS FOR THE JUSTICE SYSTEM

TUESDAY, APRIL 4, 2000

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

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2254, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Ose, Towns, Mink, Kucinich, and Schakowsky.

Staff present: Sharon Pinkerton, staff director and chief counsel; Steve Dillingham, special counsel; Don Deering, congressional fellow; Lisa Wandler, clerk; Cherri Branson, minority counsel; and Jean Gosa, minority assistant clerk.

Mr. MICA. Good morning.

I would like call this hearing of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources to order.

With concurrence of the minority, we are going to go ahead and begin our hearing. We will be joined by other Members who are currently at other meetings. It will allow us to proceed with the business before us.

This is a hearing on drug treatment options for the justice system. We have two panels of witnesses before us today. We will start the proceedings with opening statements. I will begin and will yield to other Members. We will also leave the record open for 2 weeks for additional statements by unanimous request and so ordered.

This morning's hearing is going to focus on drug treatment options for our judicial systems. Our subcommittee will examine drug treatment programs and options that hold promise, we hope, in reaching eligible, nonviolent offenders.

The focus of our hearing is very straightforward and of critical importance to our Nation. Can we identify approaches and programs for eligible, nonviolent offenders that are successful in bringing the chains of drug addiction and reinforcing individual responsibility and also restoring productive workers to our work force, which result in substantial cost savings to our American taxpayers?

If that is possible, we hope that it is an objective we can meet and also shed some light on through today's hearing. If we can, we should act without delay in supporting these programs on a national level.

First, we will examine a growing program for handling eligible offenders and drug abusers within the judicial system that has been used for almost a decade in some jurisdictions and appears to be enjoying continued success. The approach I am referring to is generally referred to as drug courts.

Drug courts were first implemented by States and local governments which contain our true laboratories of democracy. One of the original drug courts was established more than a decade ago in my home State in Dade County, FL. Specialized drug courts are designed to improve the processing of drug cases, and to respond better to the needs of eligible offenders with drug abuse problems.

Another benefit of drug courts is cost savings resulting from reduced burdens on our jails and on our prisons. Federal funding to support this effort first began in 1989 and took the form of Department of Justice discretionary grants to expedite the processing of drug cases.

By 1991, the Department also funded what are known as drug night courts, both under its discretionary grants of the Edward Burn Memorial State and Local Law Enforcement Assistance Program, also referred to commonly as Burn grants.

This program was named for Eddie Burn, a slain New York City police officer who was brutally murdered in 1988 while enforcing drug laws. For many years, the Burn Program has also served as the primary source of Federal funding for State and local assistance, law enforcement, and drug control efforts.

President Bush kept Eddie Burn's badge in his desk drawer in the Oval Office at the White House. I am perplexed, however, today at how the Burn Grant Program and antidrug effort have fallen out of favor with the Clinton administration. Last month, the Clinton administration's budget submission to Congress proposed reducing the funding of the Burn formula grants by $100 million. Congress previously funded the program at the $500 million level. The administration also requested that funding for local law enforcement block grants be eliminated.

I feel strongly that the administration should refocus its efforts on drug control and that, in fact, our Department of Justice should do everything possible to once again incorporate antidrug elements into all of our block and discretionary grant programs.

Congress has continued to increase Federal funding for drug courts, prosecutor training, and drug treatment for offenders since 1989, eventually leading to the creation of a special funding program for our drug courts.

As we will hear today, there are now more than 400 drug courts nationwide. For the past 2 years, Congress has funded the drug court program at the level of $40 million annually with additional funding eligibility under our Burn Grants Program and also under our Juvenile Block Grants Program.

We will hear from experienced analysts who will testify on the operation and impacts of our drug courts and describe how they have successfully spread across our Nation. We will also hear of another innovative approach and a 10-year success story in providing drug treatment to eligible, nonviolent offenders. That program has been operating since 1990 in Brooklyn, NY. It has received

quite a bit of notoriety for its success. That program is called the Drug Treatment Alternatives to Prison [DTAP].

Although this program has not received the level of attention and Federal support as the Drug Court Program, I plan to do whatever possible to ensure that this successful approach receives increased attention and also bipartisan support in the future.

I am very pleased to have a distinguished witness before us today; the District Attorney for King's County, NY, Mr. Charles Hynes, one of those individuals responsible for the development of this program. He will explain in detail the workings of this alternative prison program.

As we know, as much as 90 percent of State and local criminal prosecutions are resolved through plea bargaining today. Plea bargains prevent our criminal justice system by bringing it to a screeching halt with the sheer volume of cases that they are incurring today.

The DTAP Program is managed by the local prosecutor. It allows prosecutors to select only eligible, nonviolent offenders for a rigorous program that mandates drug treatment and strict observance of program rules and conditions. The prosecutor uses the leverage of a substantial prison sentence which can be invoked if an offender violates the program requirements.

The program provides a common sense, cost effective option for prosecutors, as well as a valuable opportunity to offenders who are serious about reforming their lives. As we will learn today, evaluation results of the program indicate high treatment retention rates, low recidivism, and significant cost savings, all elements that the subcommittee and Congress are interested in pursuing.

The 1 year retention rate in drug treatment is as much as 66 percent. The recidivism rate for participants is less than half for comparable offenders, 23 percent compared to 57 percent. Nearly all employable program graduates, 92 percent, are working in vocational programs; only 26 percent were employed prior to entering the program. The program has saved the city and State of New York more than $15 million.

Our subcommittee was able to visit this program last December and I was able to see firsthand some of the positive results of this program. Today, I am announcing my plans to introduce legislation which I am entitling, "Prosecutor Drug Treatment Alternatives to Prison for Nonviolent Offenders Program," a little lengthy but it does describe what we are trying to achieve with this initiative.

It will provide seed funding for State and local prosecutors to establish their own drug treatment alternatives for eligible, nonviolent offenders who desire to turn around their lives, and we are going to use the success of DTAP in Brooklyn as a model.

I hope to enlist the support of other Members of Congress who are also interested in enhancing our arsenal of successful approaches to reducing the demand for drugs across this Nation. This program is an innovative, proven program and I think it will also supplement the role of our drug courts which has also been another successful program.

This program represents a first important step in fighting the war on drugs in addressing the treatment needs of eligible, nonviolent offenders. That is an area I think we have ignored that

needs our attention. Experience has shown that this approach can break addictions, protect lives, assist families, promote employment, and save substantial tax dollars.

When I visited the DTAP Program and talked personally with the offenders in this drug treatment program, I saw that it was making an important difference in their lives and some of them their whole lives. Almost all of them I talked to, some in their mid-30's, had spent half their lives in prison or in the revolving door of our criminal justice system or victims of addiction.

This program will give them an alternative. This program will be funded, that I propose, through grants administered by the U.S. Department of Justice. The funds will go to every State and directly to urban, suburban, and rural communities with demonstrated needs and interest in programs of this nature.

I welcome all of our distinguished witnesses today and thank each of you for taking time out of your schedules, your busy professional lives, to share with the subcommittee both your experience and your recommendations on this important topic. I hope we will be able to work together to ensure that the future drug demand reduction successes such as the ones I have talked about are put into place immediately. Time is short and lives really remain in the balance. We must act now if we are going to make a difference, particularly for so many of those that have no alternative but prison today.

I am pleased at this time to yield to the gentleman from California, Mr. Ose.

Mr. OSE. None.

Mr. MICA. No opening statement.

Mrs. Mink has not arrived at this point, but we shall proceed. We have Ms. Schakowsky. Did you have an opening statement?

Ms. SCHAKOWSKY. No.

Mr. MICA. She doesn't have an opening statement at this time. Again, we will leave open the record for a period of 2 weeks for additional statements or for additions to the record.

With no additional opening statements at this time, I am going to introduce our first panel of witnesses. The first panel consists of Judge Jeff Tauber, president of the National Association of Drug Court Professionals from Alexandria, VA. The second witness is the Honorable Charles J. Hynes, the Kings County District Attorney for Brooklyn, NY.

Let me welcome both of our panelists. Let me also inform you that we are an investigations and oversight subcommittee of Congress. For that, we do swear our witnesses. If you will stand to be sworn, raise your right hands, please. Do you solemnly swear that the testimony you are about to give before this subcommittee of Congress is the whole truth and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. MICA. The witnesses answered in the affirmative.

Welcome, both of you. At this point, normally we run the clock. However, we won't run the clock today, because we only have two witnesses on this panel. If you have additional or lengthy statements you would like made a part of the record or some data or information that deserves to be entered into the record, I would be glad to grant that request.

We have been joined now by the ranking member of our subcommittee, the Honorable Member from Hawaii. Before we proceed with our two witnesses who I have introduced and sworn, it is my pleasure to recognize the gentlelady from Hawaii, Mrs. Mink, for an opening statement.

Mrs. MINK. Thank you, Mr. Chairman. That is perfect timing.

I want to personally thank you for accommodating my concerns about the drug problem in Hawaii and enabling the subcommittee to have a hearing in Hawaii on this very important matter. I thought the hearings were very productive.

Mr. MICA. I am still recovering from my 22-hour flight back here.

Mrs. MINK. I am sorry you could only stay 36 hours. That is not our fault, that is the leadership. We would have loved to have you stay longer.

This matter of the criminal justice system's use of drug treatment as an alternative to incarceration is a very important subject. I believe that our discussions today will add a great deal to what we have already learned.

The trip we took to Hawaii, we met and talked extensively with inmates who were undergoing drug treatment in the closed prison system environment. They were eligible for this treatment I believe 14 months before their release. We had an opportunity to sit around and talk with about five or six of them, to hear the various details of their experience and how the treatment was going to impact their ultimate release and their ability to stay out of prison again. The difficulties that they anticipated upon release were quite profound.

We also had an opportunity to visit the drug court and to see how that system operates as an alternative to imprisonment, and to see whether that works. Definitely the criminal justice system has a role, not only in law enforcement but in this very difficult area of drug treatment.

I look forward to our discussion today and ask unanimous consent that my statement be put in the record at this point.

Mr. MICA. Without objection, so ordered.

[The prepared statement of Hon. Patsy T. Mink follows:]

DRAFT OPENING STATEMENT

Mr. Chairman, thank you for holding today's hearing to examine the criminal justice system's use of drug treatment as an alternative to incarceration or as a component of the sentencing process.

As a part of our recent subcommittee trip to Hawaii, we met and talked extensively with inmates who were undergoing drug treatment prior to their release. While the details of their stories were different, the broad outlines were the same. They were neglected or abused children who had trouble in school, began to use drugs and got into trouble with the law. Through intensive counseling and treatment, they have taken the necessary steps to turn around their lives. And while each of them realizes that failure was a possibility, drug treatment had taught each of them that there was another way to live.

Our itinerary also included an opportunity to observe a drug court. We heard the judge question each of the offenders about job, school and

family responsibilities. After the court session, we spoke to the judge about the use of drug testing, counseling, graduated sanctions, and other means to keep offenders on the path to become productive members of society. I think those experiences gave us a richer understanding of how intricately intertwined drug use and criminal behavior can be and what society can to to provide the means to help people change thier lives.

In 1999, the National Institute of Justice's Arrestee Drug Abuse Monitoring Program (ADAM) found that more than 60% of adult male arrestees test positive for illegal drugs. The National Center on Addiction and Substance Abuse (CASA) estimates that 80% of the men and women who are behind bars–about 1.4 million people are seriously involved with drug and alcohol abuse. Yet according to the Bureau of Justice Statistics, only about 55% of jails offer some type of treatment to inmates. We have heard testimony in previous hearings, that the cost of drug treatment would add only about $10 per day to the current $56 per day average cost of incarceration. A study by CASA concluded that if only 10% of inmates are given one year of residential treatment and stay

sober and employed following release, prison-based drug treatment would pay for itself in one year. These statistics underscore the need for expanded drug treatment within the criminal justice system. Mr. Chairman, $10 per day is a small price to pay to change lives, provide hope, and improve the quality of life for all of us.

So while I think drug and alcohol abuse treatment within the criminal justice system is important, we cannot ignore the need for increased funding for voluntary, treatment which is delivered on a public health model. We cannot ignore that the Office of National Drug Control Policy has estimated that 50% of adults and 80% of juveniles are turned away from voluntary treatment because of a lack of space. We should not create a system where there is abundant treatment in prison and none on the outside. We would not want to force people commit crimes to get drug and alcohol treatment.

Mr. Chairman, I share your concerns that drug treatment should be made available to people in the criminal justice system. Our drug policy

in the last 15 years has shown that arrests alone are not the answer. Although 1.8 million people are currently in jail, the tide of drugs and the scourge of addiction continues. We must take the next logical step and provide treatment to all who seek it.

Mr. MICA. I know that many who didn't get to go to Honolulu, HI, and visit are disappointed. I had envisioned sandy, beautiful beaches, young women in grass skirts. Instead I was greeted by the ranking member who took me immediately to the Honolulu Police Station and from there took me to the State prison where we spent most of the afternoon. Next, we went to a housing project with local authorities. The next day we had a 5-hour hearing and then I thought maybe those beaches were still going to be seen, but we ended up in drug court for the afternoon before catching our flight to fly all night. I have a new admiration for our ranking member who does this on a regular basis, going back and forth.

Mrs. MINK. That just shows you, Mr. Chairman, how important treatment is.

Mr. MICA. Yes. I needed treatment when I got back. [Laughter.]

Again, I thank the ranking member for her invitation. It was a very productive hearing and visit. I thank her for that opportunity.

Once again, we have our two witnesses, Judge Jeff Tauber, president of the National Association of Drug Court Professionals and the Honorable Charles J. Hynes, Kings County district attorney, Brooklyn, NY. I will recognize first, Judge Jeff Tauber. You are recognized and I also understand you have a video. You are free to proceed.

STATEMENTS OF JUDGE JEFF TAUBER, PRESIDENT, NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS; AND HON. CHARLES J. HYNES, KINGS COUNTY DISTRICT ATTORNEY, BROOKLYN, NY

Judge TAUBER. Good morning.

Chairman Mica, Representative Mink, and esteemed members of the Criminal Justice, Drug Policy, and Human Resources Subcommittee of the House Committee on Government Reform, my name is Jeff Tauber. I am a former judge of the Oakland-Alameda County Drug Court and president of the National Association of Drug Court Professionals.

Thank you for affording me this opportunity to testify before you today to address drug courts and other innovative drug treatment and drug testing programs in the criminal justice system. Before I begin speaking about these programs, I would like to show you a brief 5 minute video. A little bit of background, last year was our 10th year of drug courts. ABC national news did a short, 3-minute news tape on the national conference. I think it portrays in a very visceral way where drug courts have come from, their effectiveness, and where they are going.

Following the film is an actual visit or segment of a visit to a drug court in San Diego where Judge Sue Finley sits. I might add that Judge Finley is a former judge, recently retired, but previously had been dean of California Judicial College and a well respected judge in the California State system.

You will see her dealing with someone who is in relapse in a very different way than you would expect in a traditional court system. The significance of the two I think demonstrates the effectiveness of drug courts. I might add that when we first began our association in May 1994, there were 24 persons sitting in a room in Alexandria from 12 drug courts. Today, I am pleased to announce that

our conference in Miami had some 2,400 persons and roughly 700 drug courts existing and being implemented. So we have come a long way in a short time. If we could roll that short segment now?

[Video presentation.]

Mr. TAUBER. Perhaps for those who haven't seen a drug court, that gives you just a glimpse at the kind of balance, both toughness and support that a drug court provides to the offender coming through the program.

At this time, I would like to continue my remarks. Senator Ben Nighthorse Campbell stated in the Congressional Record on May 26, 1999, "Drug courts are revolutionizing the criminal justice systems. Statistics show us the drug courts work, they are clearly cost effective and help convert many drug-using offenders into productive members of society. Traditional incarceration has yielded few gains for our drug offenders."

What is a drug court? A drug court is a special court that is given the responsibility to handle cases involving drug using offenders through comprehensive supervision, drug testing, judicial monitoring, treatment services, immediate sanctions, and incentives. Drug courts bring the full weight of all intervenors to deal with their substance abuse problems. That means judges, prosecutors, defense counsel, substance abuse treatment specialists, probation officers, law enforcement and corrections personnel, educational and vocational experts, community leaders, and others.

In addition, they ensure consistency in judicial decisionmaking and enhance the coordination of agencies and resources increasing the cost effectiveness of programs. The design and structure of drug court programs are developed at the local level to reflect the unique strengths, circumstances, and capacities of each community. Since 1989, the drug court phenomena has been sweeping the Nation. It is very difficult to get a hard number because as we speak, drug courts are being created. We know that there are easily over 700 that are existing or in the planning stages. Sometimes it is hard to know exactly where we are within those numbers.

Since 1989, approximately 200,000 persons have actually entered drug court programs. Many of these programs have achieved remarkable success in reducing the levels of drug abuse, incarceration, and criminal recidivism among drug using offenders. That interest is heightened by the realization that these same offenders would otherwise clog our court calendars, strain our treasuries, and flood our jails and prisons.

In 1997, the General Accounting Office reported that over 70 percent of those who entered drug court programs since 1989 have either successfully completed their programs or are still currently participating. General Barry McCaffrey, Director, Office of National Drug Control Policy, has stated, "The establishment of drug courts with their judicial leadership constitutes one of the most monumental changes in social justice in this country since World War II."

More recently, Columbia University's National Center on Addiction and Substance Abuse has provided the first major academic review and analysis of drug court research to date and Dr. Steven Belenko is here and will speak specifically to that at a later moment.

Drug courts make sense as a single drug court judge and dedicated program staff apply a direct, immediate and personal approach to the drug offender handling all drug cases from start to finish. Court procedures are adapted to reflect the realities of the offender's substance abuse, a cost effective approach to the use of sanctions and incentives is applied, and coordinated programs are created for all participants, not just the offender. All participants are held accountable for their performance and government agencies and community organizations work together as part of a unified drug court system.

With almost 80 percent of arrestees testing positive for illegal substances, drug courts and drug testing are logical modifications of the traditional criminal justice system. Drug courts, in fact, mark a turning back of the judicial time clock to a time when judges ran their own calendars and were responsible for their court's operations. Defendants had to answer directly and immediately to the judge for their conduct, and cases moved slowly and purposefully through the judicial system instead of relying on negotiated pleas and other structures to speed up the court process.

I would like to add that this extraordinary phenomena is a nonpartisan phenomena. Both Democrats and Republicans have strongly supported it, Conservatives and Liberals as well. I would add it has been endorsed by the National District Attorneys Association as well as the National Sheriffs Association and on the other side, the National Legal Aid and Public Defender Associations.

For those who think of drug courts as perhaps being soft on crime, I might add that of the judges who have been drug court judges and are drug court judges, 58 percent are former prosecutors, while only 23 percent are former defense attorneys.

Drug courts are providing a model for other kinds of court involved, community based programs such as DUI drug courts, drug courts that deal with multiple DUI offenders, mental illness courts that deal with those who are duly diagnosed, domestic violence offenders and juvenile and family drug court participants and finally, most recently, reentry drug courts which actually deal with offenders who are leaving jails or prisons and enter drug courts as a means to monitor their behavior and also to provide rehabilitation services to them.

Finally, I wanted to indicate that this idea, system, or approach has spread now to the international community. There is an International Association of Drug Court Professionals. The United Nations Drug Control Program has developed its own standards for drug courts and there are some six nations now that have drug courts besides the United States and 12 more that are in the planning stages.

We believe this is an extraordinary phenomena and one we hope this committee and the Congress will continue to support.

Thank you very much for your patience.

[The prepared statement of Judge Tauber follows:]

DRUG COURTS

A COMMON SENSE APPROACH TO THE DRUG-USING OFFENDER

Testimony of Judge Jeffrey Tauber

before the House Subcommittee on Criminal Justice, Drug Policy and Human Resources

April 4, 2000

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901 North Pitt Street
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Drug Courts: A Common Sense Approach to the Drug-Using Offender

Chairman Mica, Representative Mink and esteemed members of the Criminal Justice, Drug Policy and Human Resources Subcommittee of the House Subcommittee on Government Reform, I am Judge Jeffrey Tauber, President of the National Association of Drug Court Professionals, and the former judge of the Oakland-Alameda Drug Court. Thank you for affording me the opportunity to testify before you today to address drug courts and other innovative drug treatment and drug testing programs in the criminal justice system.

Before I begin speaking about innovative court programs, I would like to show you a five-minute video that shows two drug court judges in action. The piece will demonstrate the effectiveness of drug courts, thus far, and their potential for greater things in the future. (SHOW VIDEO)

As Senator Ben Nighthorse Campbell stated in the *Congressional Record* on May 26, 1999, "Drug Courts are revolutionizing the criminal justice system . . . Statistics show us the Drug Courts work. . . [they] are also clearly cost-effective and help convert many drug-using offenders into productive members of society. Traditional incarceration has yielded few gains for our drug offenders." (*See*, **Appendix A**: Campbell, Senator Ben Nighthorse (R-CO), *Congressional Record,* Senate, "National Drug Court Week," Vol. 145, No. 77, May 26, 1999.)

So, what is a drug court? A drug court is a special court that is given the responsibility to handle cases involving drug-using offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives. Drug court programs bring the full weight of all intervenors (judges, prosecutors, defense counsel, substance abuse treatment specialists, probation officers, law enforcement and correctional personnel, educational and vocational experts, community leaders and others) to bear, forcing offenders to deal with their substance abuse problems. In addition, they ensure consistency in judicial decision-making and enhance the coordination of agencies and resources, increasing the cost-effectiveness of programs. (*See*, **Appendix B**: *Facts on Drug Courts and Drug Court Systems*, National Association of Drug Court Professionals, 1999.)

The design and structure of drug court programs are developed at the local level, to reflect the unique strengths, circumstances and capacities of each community. Since 1989, the drug court phenomenon has been sweeping the nation. Currently, there are approximately 700 innovative drug court programs in the planning stages or having been implemented, and since 1989, about 200,000 persons have entered drug court programs. Many of these programs have achieved remarkable success in reducing the levels of drug abuse, incarceration and criminal recidivism among drug-using offenders. That interest is heightened by the realization that these same offenders would otherwise clog our court calendars, strain our treasuries and flood our jails and prisons. (*See,* **Appendix C**: Kay,

Judith S., New York State Chief Judge, "Making the Case for Hands-on Courts," *Newsweek,* October 11, 1999.)

In 1997, the Government Accounting Office (GAO) reported that over 70% of those who entered drug programs since 1989 have either successfully completed their program or are still currently participating (U.S. General Accounting Office. *Drug Courts: An Overview of the Growth, Characteristics and Results*. Gaithersburg, MD: U.S. General Accounting Office, 1997). General Barry McCaffrey, Director of the Office of National Drug Control Policy, Executive Office of the President stated that, "the establishment of drug courts with [their] judicial leadership constitutes one of the most monumental changes in social justice in this country since World War II" (NADCP 4th Annual Training Conference, Washington, DC, 1998).

More recently, Columbia University's National Center on Addiction and Substance Abuse (CASA) has provided the first major academic review and analysis of drug court research to date. The author, Dr. Steve Belenko, reviewed 30 evaluations pertaining to 24 drug courts across the nation and concluded that drug courts provide closer, more comprehensive supervision and much more frequent drug testing and monitoring during the program, than other forms of community supervision. More importantly, the study found that drug use and criminal behavior are substantially reduced while offenders are participating in drug court. (*See,* **Appendix D**: Belenko, Ph.D., Steven. *Research on Drug Courts: A Critical Review,* Alexandria, VA: National Association of Drug Court Professionals, 1998).

Drug courts make sense, as a single drug court judge and dedicated program staff, apply a direct, immediate, and personal approach to the drug offender, handling all drug cases from start to finish. Court procedures are adapted to reflect the realities of the offender's substance abuse. A cost-effective approach to the use of sanctions and incentives is applied. Coordinated programs are created, where all participants (not just the offender) are held accountable for their performance, and government agencies and community organizations work closely together as part of a unified drug court system. With almost 80 percent of arrestees testing positive for substances, drug courts and drug testing are a logical modification of the traditional criminal justice system.

Drug courts, in fact, mark a turning back of the judicial clock to a time when judges ran their own calendars and were responsible for their court's operations. Defendants had to answer directly and immediately to the judge for their conduct, and cases moved slowly and purposefully through the judicial system (instead of relying on sentencing guidelines, mandatory minimums and negotiated pleas to speed up the court process).

The following delineates how drug courts work, how they are different from the traditional court and what the underlying principles are that makes them successful.

I. THE JUDGE'S ROLE IN A DRUG COURT: IMPLEMENTING THE NEW JUDICIAL INTERVENTION STRATEGY

There is a persistent belief in the judicial community that a drug-using offender's failures while under court supervision are willful and deliberate and consequently ought to be dealt with severely. Unfortunately, this belief minimizes the compulsive nature of drug abuse and exaggerates the offender's ability to refrain from continued drug usage (as well as the court's ability to coerce abstinence).

The drug court judge recognizes the limitations of judicial coercion as a drug rehabilitation tool and rejects the notion that program failure is necessarily the result of the willful defiance of judicial authority (and therefore, punishable as a kind of contempt of court). In its place, drug court judges have adopted a new and pragmatic judicial intervention strategy. That strategy relies on the development of an ongoing, working relationship between the judge and the offender and the use of both positive and negative incentives to encourage compliance.

The Drug Court as Theater

In a drug court, communications between the judge and the offenders are crucial. By increasing the frequency of court hearings, as well as the intensity and length of judge/offender contacts, the drug court judge becomes a powerful motivator for the offender's rehabilitation.

A successful drug court depends on the willingness of the judge and staff to work together as a team. The team sees its job as the facilitation of the offender's rehabilitation. Traditional roles are vacated in drug court

A drug court judge performs on the courtroom stage before an audience full of offenders. As appropriate, the judge assumes the role of confessor, taskmaster, cheerleader, and mentor; in turn exhorting, threatening, encouraging and congratulating the participant for his or her progress, or lack thereof.

The court hearing itself is used to educate the audience (as well as the offender) as to the potential consequences of the program. In-custody offenders who have failed the program are seen early in the hearing before a full audience of participants, while successful graduates are often handed diplomas by the judge accompanied by the applause and congratulations of staff.

The Importance of Judicial Leadership

A drug court provides direction and focus through the leadership of a single judge. Such focused leadership insures consistency in judicial decision making and program implementation, coordination and accountability of participating agencies and staff and cost-effectiveness through direct "calendaring" and efficient case management.

Many judges tend to regard any judicial activity outside of the courtroom with suspicion. In actuality, however, judges can only be as effective in their courtroom if the systems that they build outside of that courtroom will allow.

By way of example, in the traditional court system in Oakland, California, more than 1/3 of defendants failed to appear for their diversion eligibility hearing when that hearing was held six to eight weeks after their arraignment and release from custody. With the advent of the FIRST Diversion Program, the delay between arraignment and a diversion eligibility hearing was reduced from six weeks to a single day, facilitating the immediate intervention in the offender's drug usage. Consequently that failure to appear rate dropped from approximately 36 percent to three percent.

Sharing Power

Judicial leadership involves more than a willingness to lead. Drug court programs look beyond traditional relationships to the forming of innovative partnerships that feature collaboration in decision making, sharing of resources, and coordination of efforts.

It is crucial that all program staff participate fully in the design and implementation of the program. Program staff shares in the ownership of the program and understand that program success is in both their institutional and personal interest. Such staff commitment to program success is one of the most valuable assets that a drug court program offers.

II. THE REALITY-BASED DESIGN PRINCIPLES OF A DRUG COURT

Court ordered drug rehabilitation programs suffer from the generally held belief that "nothing works" in the treatment of drug-using offenders. Unfortunately, that perception (although untrue) becomes a self-fulfilling prophecy when financially strapped communities inadequately fund court-ordered treatment programs and skeptical judges half-heartedly implement those programs (often terminating participants with the first sign of drug relapse). *It takes more than increased funding and full judicial support to create an effective Drug Court program. Successful Drug Court programs are based on an understanding of the physiological, psychological, and behavioral realities of drug abuse and are implemented with those realities in mind.*

Such programs recognize that drug abuse is a serious, debilitating disorder; that relapse and intermittent progress are a part of most successful drug rehabilitation; that as since a drug addiction is not created overnight, it cannot be cured overnight; that a drug user is most vulnerable to successful intervention when he or she is in crisis (*i.e.,* immediately after initial arrest and incarceration); that drug users are in denial and will do everything possible to avoid responsibility, make excuses for program failure and evade the court and its programs.

Numerous jurisdictions across the country have developed successful drug courts and court ordered drug rehabilitation programs that recognize and work with, rather than against, the realities of drug usage. As a matter of fact, Chairman Mica, a number of drug courts exist in your state!

Although these programs often have substantially different programs characteristics reflecting their individual circumstances, what is crucial is that they share the same underlying "reality-based" design principles.

Features of a Reality-Based Drug Court:

1. Immediate and Upfront Intervention

Reality: A drug addict is most vulnerable to successful intervention when he or she is in crisis (*i. e.*, immediately after initial arrest and incarceration).

Principle: Intervention should be immediate and front-loaded.

Even the best designed, court-ordered drug rehabilitation program will be less than effective when intervention is delayed. Recognizing this, drug courts order participants to begin treatment immediately after their court hearing. (*E.g.*, in Miami, participants are transported by van, but in Oakland they are ordered to appear within 15 minutes of the court hearing.)

For the same reason, supervision and treatment should be front-loaded; to engage the participant early and often, giving the program and treatment the opportunity to take root. Most drug courts require at least three supervision and treatment contacts a week during the first six weeks of the program.

2. Coordinated, Comprehensive Supervision

Reality: If there are gaps in program supervision, the offender will find and exploit them.

Principle: Supervision must be comprehensive and well coordinated to insure accountability.

Few offenders enter the court's programs with rehabilitation on their minds. They are in denial, and are there mostly to beat the system and avoid incarceration. The challenge is to keep them in the program until sobriety, and attitudinal changes can occur. This may be difficult to accomplish, since the drug-using offender is often an expert at avoiding responsibility, making excuses for his or her failures and evading the court and its programs.

The drug offender must be held accountable for his or her conduct, if rehabilitation is to be successful. A drug court program forces a drug-using offender to submit to frequent supervision contacts and drug testing, provides direct access to full information on the drug offender's progress, immediately responds to program failures and coerces the offender to frequent progress hearings before a single drug court judge and permanent staff.

3. Long-Term Treatment and Aftercare

Reality: A drug addict is not created overnight, and therefore cannot be cured overnight.

Principle: The drug-using offender needs intensive, long-term treatment and aftercare.

Drug addiction is a serious, debilitating disorder that demands intensive, long-term treatment. (It takes most drug court participants an average of one year to successfully graduate from the program). Treatment preferably begins in a medically-supervised jail drug detoxification unit. For most participants, however, a community-

based, non-residential treatment program is the initial treatment experience. More costly residential treatment spaces are generally reserved for those who have not responded well to non-residential treatment.

Without adequate aftercare, an offender's sobriety may be short-lived when he or she faces the same problems that contributed to the drug usage in the first place. A drug court rehabilitation program should include ancillary services, such as ongoing drug treatment and counseling, as well as educational opportunities, job training and placement and health and housing assistance.

Because of the custodial issue of ex-offenders' criminality, the concept of **reentry drug courts** has become important. These courts provide a mechanism for the successful reintegration of the serious drug-using offender back into society. This is accomplished by keeping offenders engaged in corrections-based treatment and court-based monitoring throughout their custody term and, once released, providing a continuity of appropriate treatment and court-based accountability in the community.

The reentry court's involvement begins at the onset of the offender's jail term and continues beyond the date of custodial release. The drug court is a logical mechanism that can help support an offender's successful return to the community, as it provides a combination of incentives, structure, services, accountability and ongoing supervision.

4. **Progressive Sanctions and Incentives Program**

Reality: Relapse and intermittent progress are part of most successful drug rehabilitation.

Principle: The court must apply a patient, flexible approach in monitoring compliance.

In most cases, progress toward rehabilitation will be slow and fitful, with sobriety only taking hold over a period of months. Progressive sanctions and incentives are incrementally applied in response to success and failure to move participants toward sobriety.

III. SMART PUNISHMENT: A DRUG COURT'S SENTENCING PHILOSOPHY

The judge who uses extended incarceration as the only response to drug usage is like a carpenter who shows up at a job site with only a hammer: he or she does not possess the tools to complete the job. The drug court judge carries intensive supervision, counseling, educational services, residential treatment, acupuncture, medical intervention, drug testing and program incentives AND incarceration in his or her tool box.

The problem is not in the use of incarceration, but in our over-reliance on it. Incarceration works for drug-using offenders. It works by providing the offender with the opportunity to detox from drugs. It works as a deterrent, by presenting the offender with the stressful, anxiety producing experience of incarceration. It works by coercing drug-using offenders to enter and complete rehabilitation programs.

The use of extended periods of incarceration, however, does not appear to increase the value of incarceration and may be counter-productive to sentencing goals. Extended incarceration may disrupt whatever stability exists in a drug-user's life (needed for successful drug rehabilitation), initiate him or her into a criminal lifestyle and reduce the deterrent effect of incarceration, thus limiting the effectiveness of court-ordered rehabilitation.

Smart punishment is the imposition of the minimum amount of punishment necessary to achieve the dual sentencing goals of reduced criminality and drug usage. It relies on the use of progressive sanctions, the measured application of a spectrum of sanctions, whose intensity increases incrementally with the number and seriousness of program failures.

Progressive Sanctions

In a drug court, there are immediate and direct consequences for all conduct. Sanctions follow violations and are applied as close to the time of failure as possible. This calls for frequent court hearings to monitor the offender and mete out sanctions.

In many drug courts, less serious violations, such as inadequate participation in a court-ordered program, call for sanctions that start with the intensification of supervision, treatment or a single day's incarceration. Those sanctions increase incrementally (*i.e.*, 1 day, 2 days, 4 days, etc.) with continued violations. At the other end of the spectrum,

complete program failure (represented by an offender permanently absenting him or herself from court or treatment program) may call for a substantial period of incarceration (at least one week) to detox the offender, as well as deter the offender from future program failure or drug usage.

Diversion and Other Incentive Programs

Drug rehabilitation is at best a difficult, demanding, and lengthy process. In order to motivate defendants to complete that process, drug courts offer them substantial incentives to do so. Encouragement, appreciation and other incentives are given to participants for positive behaviors.

A diversion program provides a powerful motivational tool for drug rehabilitation, offering a defendant the opportunity to work toward a complete dismissal of a felony drug charge. Hybrid diversion programs that do not offer a complete dismissal (*i.e.*, offering to reduce felony convictions to misdemeanors) are common but provide less incentive for participants to succeed. Even where a diversion program is not available at all, significant incentives are often offered to offenders through the innovative application of probation terms (*i.e.*, offering participants' reductions in the length, intensity or cost of probation supervision).

The most progressive and successful drug courts involve both diversionary and probationary segments involving all drug-using offenders living or incarcerated in the community.

IV. STRUCTURAL ACCOUNTABILITY: PROMOTING COORDINATION

For a drug court and its accompanying court-ordered drug rehabilitation program to be effective, participating agencies must look beyond their own interests (*e.g.*, distribute information freely, collaborate in decision-making, share resources and coordinate efforts) to work as a team.

While strong leadership and individual commitment may initially create a climate conducive to coordination, programs may experience modifications (through personnel changes or burnout). It is crucial, therefore to develop permanent structures that will insure continued program coordination, stability, and effectiveness over time.

Structural accountability exists where participating agencies share program responsibilities and are accountable to each other for program effectiveness. Each part of the system (supervisory staff, public defender, prosecuting attorney, treatment provider, court staff and judge) is directly linked to, dependent upon and responsible to the others.

The Structurally Accountable Characteristics of a Drug Court

1. A Unified Drug Court

A single drug court judge and dedicated court staff (handling all drug rehabilitation cases from start to finish) is the focus for program design, implementation, and monitoring.

2. Co-funding of a Coordinated System

Joint responsibility as to funding decisions for the program among criminal justice, rehabilitation and community-based organizations promotes an integration of function and sense of responsibility for the total program.

3. Community-wide Planning

Full interagency and community-wide participation in the design and implementation of the program promotes agency and community commitment to, and ownership of, the program.

4. Program Procedures and Guidelines

The setting of clear procedures and guidelines describing program requirements and consequences informs all participants (including offenders) as to what is expected of them.

5. Setting a Mission and Goals

Court and staff develop, and agree on, program goals towards which they can work and against which they can measure their progress.

6. Periodic Review

Interagency and community review of the program permits continuous evaluation of program and agency effectiveness, troubleshooting for problems and the maintenance of inter-agency relationships.

7. Hands-on Vertical Participation

The same agency personnel see the offender throughout the entire process, promoting personal responsibility and commitment to the offender's progress.

8. Developing Partnerships

Participating agencies look beyond traditional relationships, redefining their roles and sharing in decision making formerly reserved to a single agency.

9. Data Collection

The collection of pertinent information is essential in determining whether the goals of the program are being met and in planning for new ones.

10. Full Access to Program Information

Complete access to information on the work of participating agencies allows them to better understand each other's role and work together more effectively.

11. Direct Linkages

Developing mechanisms for the face-to-face meeting of all participants (including the offender) promotes the monitoring of the offender's progress and the work product of staff.

12. Personnel Incentives

Providing incentives for the effective performance of work done and rewards for the special contributions of individuals, promotes staff innovation and productivity.

V. A UNIFIED DRUG COURT SYSTEM

All government programs require the effective operation of participating agencies. However, because the task involved in the rehabilitation of drug-using offenders is Herculean, a higher degree of competence, coordination and accountability is required of both program personnel and the structures they create. A unified drug court system provides the opportunity to coordinate a wide range of anti-drug strategies, from rehabilitative to treatment services, probation and parole, education and job training and police services.

The most basic drug court design requires the daily communication, cooperation, and linkage of judge and court staff, supervising agency, treatment providers and prosecution and defense bar. Attributing the success of a drug court to the judge alone is like saying the safety record of a jet airliner is the sole responsibility of the pilot (omitting the crew, mechanics and air traffic controllers). A unified drug court system is a circular system, with each participant linked to, dependent upon, and responsible to the others. (*See,* **Appendix E**: Diagram of drug court team members.)

Drug Courts as the Focus of an Anti-Drug System

The courts stand in a unique position in the community; they are at the fulcrum, where service agencies meet. Participating agencies are used to working closely with or under the supervision of the courts. In fact, the court is the only place that some agencies (such as police and treatment) ever have significant contact. Even agencies that are hostile and uncooperative with each other work effectively and cooperatively within the court's orbit.

Judges, too, have a special position in their communities that make drug courts the logical place to focus anti-drug efforts. Encouraging community involvement and participation in the unified drug court system will ensure that the drug court system will continue to access existing community resources, create new and stable linkages with community organizations and cement itself into the community's infrastructure.

Continuing to Expand the Drug Court Concept

Much like the reentry drug court concept about which I spoke earlier, the drug court model has begun to extend to other types of court-based initiatives. One such model is that of mental health courts which employ the identical rationale that is behind the drug court concept: the court should take an active role in assisting those individuals who are involved in the criminal justice system due to an illness (or addiction).

A recent study conducted by the Urban Institute indicated that 39% of all homeless individuals show some sign of mental illness and almost 25% of those behind bars suffer from mental illness. Another study, conducted by the U.S. Department of Justice, revealed that many of these individuals (more than 250,000) were in America's jail or prison system, and over half a million (548,000, to be exact) were on probation and living in our communities in 1998.

These mentally ill individuals end up involved in the criminal justice system, often for non-violent, "less serious" crimes (*e.g.,* vagrancy). Similar to the plight of drug addicts before the advent of drug courts, the criminal justice system has become a revolving door for many of the mentally ill who receive little or no treatment while incarcerated, only to be released back into the community. More often than not, and similar to untreated drug addicts, these individuals repeatedly return to jail or prison.

Much like those who created drug treatment courts, a judge in Broward County, Florida began the first mental health court in the United States, designed to divert non-violent, mentally ill people into treatment under the umbrella of the court. She and her "mental evaluation team" have diverted over 1,200 mentally ill people into treatment. As a result of the success in Broward County, numerous mental health courts are being developed throughout the nation.

The possibilities for expansion of the drug court concept into other areas of the criminal justice system are limitless.

VI. CONCLUSION

I would like to sum up today by noting that drug courts are a rational alternative to traditional case processing in the criminal justice system. In the traditional system, once released, offenders often continue to commit crimes, supporting their untreated habits. Drug court programs enable allied professionals to break the cycle of drug addiction and crime by removing the addiction that causes the offenders to commit the crimes and holding the offender accountable. Drug courts are a win-win situation for the public, law enforcement and addicts.

Thank you for allowing me to testify today.

Appendix A

Statement from the *Congressional Record*

Appendix B

Brochure: *Facts on Drug Courts and Drug Court Systems*

Appendix C

Article from *Newsweek:* "Making the Case for Hands-on Courts"

Appendix D

Study: *Research on Drug Courts: A Critical Review*

Appendix E

Diagram of Drug Court Team Members

Mr. MICA. Thank you, Judge Tauber.

I would now like to welcome the Honorable Charles Hynes, District Attorney, Kings County, NY.

Mr. HYNES. Thank you, Mr. Chairman and Congressman Ose. I surely want to thank Chairman Mica and Congresswoman Mink and the other members of the committee, and my distinguished colleague from Brooklyn, Ed Towns, for the opportunity to speak to this committee about our drug treatment as an alternative to prison.

I have copies of the annual report which I have submitted and I would like to touch on a few highlights of the program. My county is known to most people as Brooklyn and is the largest county in New York State. It has 2.3 million people, the seventh largest county in the United States and were it a city, it would be the fourth largest.

At the time I became district attorney in 1990, our slogan was, "Brooklyn, a nice place to visit, a great place to live," a cruel joke because by 1990, Brooklyn had become the fifth most violent municipality in the United States per capita. There were 765 murders in Brooklyn in 1990, more than 2 a day. There were 36,000 armed robberies, 39,000 burglaries and nearly 55,000 larcenies. Obviously, anybody looking at the problem knew it was fueled by drugs. It was out of control and there didn't seem to be any way of looking at this other than a jail being only solution.

It was a decision I made in 1990 that we had to do something about reducing the demand for drugs in society. So we had to do something about ending the revolving door that literally had people going to jail for life on the installment plan, getting arrested, going to jail, getting out, going back to the neighborhood without a job, getting arrested again, and off they go to jail and so on.

We decided to try a coercive form of rehabilitation, that people who were charged with selling drugs for their own drug habit would have a choice, come into our program, go into long-term drug rehabilitation, 15 to 24 months, and if you successfully complete it, we will give you something you have never had before, an education opportunity or a job opportunity.

I hired a job developer, and worked with a business advisory council in Brooklyn to identify jobs for these graduates. If you don't do it, or leave the program, we have an enforcement theme that will pick you up and when 96 percent effective within 9 days on the average, you will plead guilty before we will put you into the program to a felony that sends you to prison for as much as 9 years. If you get caught after leaving the program, you are going back to prison, or you are going to prison and will get no credit for any time served in the program.

Ten years after this program started, I am proud that it is a successful model which I am very grateful to Congressman Mica for considering legislation to advance it for other prosecutors throughout the country.

It is controlled by the prosecutors, and is very selective about who we take. Typically, we take one in three. These are all people who are facing a second felony offense, a minimum of 2–1/3 to 4 years in prison and up to 4 to 9 years in prison. We have had the toughest laws in the country called the Rockefeller drug laws. We

followed those laws up with mandatory minimum sentences for second felony offenders. The problem has been that we have had no alternative to the use of those programs. There was no opportunity to have people try another way. We think the drug treatment alternative is that other way.

No one with any history of violence is permitted into the program, no one with a history of absconding is allowed in the program, no one with any very serious psychiatric problems—we are beginning to deal with the problems of those affected in a dual way with psychiatric problems but we are very careful as to who we put into the program.

If the person successfully completes the 15 to 24 months in drug treatment and is in job development, we then dismiss the felony charge. The enforcement team is a critical part of this effort as well as the fact that we have job opportunities.

We compared a study of recidivism and our graduates have a 23 percent recidivism rate as compared to 47 percent of those who go to prison who are eligible for our program but don't accept it. It cuts the recidivism rate in half.

Its retention rate for 1 year is 66 percent, much higher than the national average and 60 percent of our participants who have graduated are still in treatment.

DTAP is a money saver. It helps our graduates find jobs because of our job training program and 92 percent of our employable graduates are working or in some form of job training programs. Of the 441 graduates, they have saved the taxpayers of New York State over $16 million in reduced costs for incarceration, health care, and public assistance and with their increased tax revenues based on their jobs.

DTAP is less costly than incarceration. A typical drug offender in New York State, spending 2 years in prison, will cost our taxpayers $82,000 for that period. In the same period, a drug treatment placement costs $42,000. The saving in prison cost is at minimum, $11 million during the period of the program.

DTAP has credibility with other prosecutors. All of the other four district attorney offices in New York City are using the program as is our citywide Special Narcotics Prosecutor.

I am very confident that based on the track record, DTAP can be successful in other States because it has shown a high retention rate, lower recidivism rates, and cost savings of millions of dollars. As I have said to Congressman Mica and his staff, I would be more than happy to help any other jurisdiction in this country to create their own DTAP initiative.

I would be happy to take any questions you may have.

[The prepared statement of Mr. Hynes follows:]

REMARKS OF DISTRICT ATTORNEY CHARLES J. HYNES
HEARING ON DRUG COURTS, PROSECUTION PROGRAMS AND DRUG TREATMENT PROGRAMS
HOUSE SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND HUMAN RESOURCES
RAYBURN HOUSE OFFICE BUILDING ROOM 2154
APRIL 4, 2000 10:00 A.M.

Mr. Chairman and members of the Subcommittee. Good morning, everyone. I would like to thank Chairman Mica and the other members of the Subcommittee for inviting me to speak to you again about our Drug Treatment Alternative to Prison program, which we call "DTAP." I have submitted copies of our annual report for the record, so I will confine myself to a few highlights about our program.

By way of background, I am the District Attorney of Kings County, New York, known to everyone as Brooklyn, which is the largest county in New York State. With its population of 2.3 million people, Brooklyn is the seventh largest county in the United States, and if it were a city, it would be America's fourth largest city. Brooklyn is home to a multitude of ethnic groups, who speak more than 100 different languages and dialects.

When I became District Attorney in 1990, Brooklyn was overwhelmed with crime. In addition to 765 homicides, there were 36,000 robberies, 39,000 burglaries and 54,800 larcenies. Since many of these crimes were committed by drug addicts who habitually stole to support their

habit, I thought it was time to stop the revolving door for those who continued to commit crimes after they were released from prison. I created DTAP because I wanted to offer a treatment alternative to drug offenders who were capable of rehabilitation.

Ten years later I am proud to report to you that DTAP is a highly successful, prosecution run drug treatment program. By relying on legal coercion, effective law enforcement techniques and good treatment providers, DTAP has enhanced public safety, maintained a high retention rate and saved taxpayers money.

First, because it is a prosecution run program, DTAP is very selective about whom it offers treatment. The program is offered only to non-violent, predicate drug offenders who face certain punishment under New York State's second felony offender law.

New York has the toughest drug laws in the nation, known as the Rockefeller drug laws, which make it a felony to sell or possess small quantities of drugs. Under the second felony offender law, which was passed two years after the Rockefeller drug laws, a defendant who is convicted a second time of possessing or selling a small quantity of drugs must be sentenced to state prison.

DTAP screens defendants to make sure that they are drug addicts who are in need of treatment, and not major drug dealers. As an added precaution, DTAP has an enforcement team that verifies the defendant's ties to the community and makes sure that there is no violent conduct which is not reflected in the defendant's criminal history.

In order to insure certainty of punishment, DTAP requires each defendant to plead guilty to a felony, so that a prison sentence will be mandatory if the defendant absconds from the program. If the defendant successfully completes 15 to 24 months of treatment in a residential facility, the charges against him are dismissed. If the defendant absconds from treatment, he is brought back to court by the enforcement team and sentenced to prison on the underlying charges. The enforcement team is so effective that 96% of the absconders are returned to court in a median time of nine days.

DTAP substantially enhances public safety by reducing recidivism. We did a three year comparative study of DTAP graduates and defendants who were paper eligible for DTAP, but did not participate in the program. We found that the recidivism rate for the DTAP graduates was 23 percent, but the recidivism rate for the non-participants who went to prison was 47

percent. In simple terms, DTAP cuts the recidivism rate for chronic drug offenders in half.

And because of the legal coercion from the second felony offender law, DTAP has a very favorable retention rate. The one year retention rate is 66%, which is much higher than the national average; and nearly 60% of our participants have graduated or are still in treatment.

DTAP is a money saver because it helps our graduates find jobs and stay out of trouble. DTAP has a job developer and a business advisory council. Ninety two percent of our employable graduates are working or in job training programs.

DTAP's 441 graduates have benefited the taxpayers of New York State by over $16 million in reduced costs of incarceration, health care and public assistance, and increased tax revenues.

DTAP is far less costly than incarceration in state and local correctional facilities. A typical drug defendant who spends two years in state and local facilities will cost the taxpayers an estimated $82,000. A typical DTAP placement for two years in a residential drug treatment program will cost the taxpayers $42,000. The corrections savings from DTAP have been more than $11 million.

DTAP has credibility with other prosecutors. It has been accepted by the four other District Attorneys in New York City, by our Special City-wide Narcotics Prosecutor, and by other prosecutors in upstate New York.

DTAP has been the subject of a five-year research effort funded by the National Institute of Drug Abuse, studying retention, post treatment outcomes, cost effectiveness and participants' perception of legal coercion. Preliminary findings based on a six month follow up of DTAP participants compared to a prison control group show that DTAP participants made greater improvements in almost all social and psychological areas and in reducing drug use. Based on these preliminary findings, the study has been extended for an additional two years to continue to measure DTAP's effectiveness.

DTAP shows that a treatment program for repeat offenders can be run successfully as an alternative to incarceration. The lessons we learned from DTAP encouraged us to support the creation of the Brooklyn Treatment Court, the largest drug court in New York State. Our court has over 1,600 participants, with charges ranging from misdemeanor to multiple felonies. Its one-year retention rate is 65%. It is staffed with an experienced assistant district attorney who has a broad range of prosecutorial discretion with regard to treatment pleas and eligibility.

We think that DTAP can be a model for prosecution run drug treatment programs in other states, as well. It has a proven track record, high retention rates, low recidivism rates and cost savings of millions of dollars.

Mr. Chairman, thank you for inviting me to talk about DTAP. I would be pleased to answer any questions the committee may have.

Mr. MICA. Thank you for your testimony.

We have been joined by the gentleman from Brooklyn, with whom I have had the honor and privilege of working together on this subcommittee and other subcommittees. One of which he chaired visited Brooklyn under his chairmanship and also recently conducted a hearing in New York City at his request; the gentleman from New York, Mr. Towns. You are recognized if you want to make a statement or proceed in any way at this point.

Mr. TOWNS. I would like to insert my statement in the record but I would also like to say to the witnesses, especially my friend from Brooklyn, the District Attorney Joe Hynes, that we know of his great work, so I am happy to hear his testimony. I will just hold any further statements until the question and answer period.

Mr. MICA. Without objection, your statement will be made a part of the record.

First of all, in the video we saw, Mr. Tauber, at the end it said the drug courts had an 80 percent success rate. Is that an accurate statement?

Judge TAUBER. It is very difficult to give statistical analysis. I am going to leave that to Dr. Belenko. For one thing, every community is so different that to ascribe a specific ratio, to compare Brooklyn to Scarsdale, for example, you have very different populations, different drugs of choice, and the level of addiction can be very different. I don't feel like I personally ought to respond to that. I will allow Dr. Belenko to do that.

Mr. MICA. Is there any percentage you would care to provide for the subcommittee as far as the success rate through the drug courts, 50 percent, 25 percent? Is there any collection of data that is available that would substantiate some success?

Judge TAUBER. Yes, I think there is. There have been a number of studies completed. One study by the Government Accounting Office looked at those persons who have entered drug courts since 1989 and found that over 70 percent have either successfully graduated from the program or were still actively participating.

It is interesting to note; American University revised or looked at that data again since 1997 in 1999 and found the numbers were consistently over 70 percent.

I also think Dr. Belenko can speak to this better than I but in his statistics, he shows that of those who do not enter drug courts but enter treatment, half leave within 90 days. When you look at drug courts, 60 percent of those who enter are still in drug courts after a year, which shows an extraordinary retention rate. All the scientific data and investigation I have ever seen has created a direct correlation between the length of time a person stays in treatment and the success of that person in the program and the length of sobriety they enjoy afterwards. On those two bases, we can see there have been great successes in drug courts.

In my own drug court we found that we had half the number of days persons spent in custody over the 3-years following drug courts and as a matter of fact, double those who succeeded and graduated from the program. Once again, that is just one program and was a number of years ago.

I think more significantly Dr. Michael Finigan from the University of Oregon did a cost benefit analysis of the Portland Drug

Court which has been around since 1992 and found that for every dollar spent in the drug court, the county was saving $2.50. When he looked at the State savings, he found some $10 saved for every $1 saved.

There is one other point I would like to make in that regard. The typical drug court costs approximately $2,000 to $2,500 a year per participant. The typical jail and/or prison starts at $20,000 to $25,000 per year to incarcerate. Clearly, there is a very strong cost savings element as well.

Mr. MICA. The other question I would have would be what percentage of those involved in committing some type of a drug offense are eligible for drug courts?

Judge TAUBER. Drug courts are a grassroots phenomena. That is where its strength is. They reflect their communities politically, economically as well as otherwise, so it is very difficult to describe to you the population that is going to get in because in one community, honestly, it will be persons charged with possession of small amounts of drugs, and in other communities, they will be dealing with people charged with burglaries, minor felonies, and others who are not even charged with drug offenses but where it is clear the offense is related to drugs.

Mr. MICA. Are they designed for first time offenders and also for minor offenses?

Judge TAUBER. They started out in Miami dealing specifically with divertees and first-time offenders. As they have become more successful, and as they have proven themselves in places like Las Vegas, San Bernardino, CA, they have gone from small programs with 100 or 75 persons in San Bernardino to where Judge Pat Morris now has some 1,400 in his drug court or Las Vegas where they started out with 100 persons and now have 1,800.

By the way, the Nevada Governor has instituted and passed legislation so that individuals presently in prison for drug offenses, some 300 this next year are expected to be released into the drug court rather than go to parole because the drug court has proven more successful than parole and is far cheaper.

Mr. MICA. I have additional questions but I would like to yield to the ranking member, Mrs. Mink.

Mrs. MINK. Judge Tauber, the system that we have in existence switched from giving courts discretion in sentencing to a huge array of mandatory minimums. In the drug court situation, how does that system circumvent the mandatory minimum requirement that the States impose upon the conviction of individuals for certain very specific crimes?

Judge TAUBER. Many States don't have mandatories or if they do, judges are able to sentence people to jail or prison and to suspend the sentence and allow them to enter the drug court program with the condition that if they successfully complete the program, the probation will be terminated or the sentence will not be served.

There are several kinds of drug courts. One is a diversion court which goes back to Miami which is a pre-plea court and most recently, we are seeing more and more, perhaps 70 percent, of courts now are post-plea courts dealing with more serious offenders and many, many courts, perhaps the majority of courts, have both di-

vergent courts dealing with light, first offenders and post-plea courts dealing with more serious offenders.

Mrs. MINK. My question was, in jurisdictions where you have minimum mandatories, how do you overcome those statutes in existence and place individuals who have pleaded guilty into this program rather than serve their minimum mandatory jail sentence?

Judge TAUBER. I couldn't respond except to say that there are drug courts in every State in the Union.

Mrs. MINK. They are not abiding by the law?

Judge TAUBER. I can tell you there are 110 drug courts in California and I think there is one in Rhode Island.

Mrs. MINK. I realize that. I am just wondering how they get started under the circumstances of these prior existing mandatories.

Mr. HYNES. Can I help out because we have mandatory sentencing in New York State.

Mrs. MINK. So do we in Hawaii and I have a drug court. I was wondering how they balance it.

Mr. HYNES. Preindictment, I have total authority in my county.

Mrs. MINK. Is that by statute?

Mr. HYNES. Yes.

Mrs. MINK. So the legislature, in my case, would have to pass a law which says that the courts would have the right.

Mr. HYNES. Once there is an indictment, there is no discretion in New York, so I do it pre-indictment.

Mrs. MINK. Or you don't require them to plead guilty?

Mr. HYNES. No, I require them to plead guilty to a State or Supreme Court information but it is pre-indictment, so I retain the discretion.

Judge TAUBER. There is a drug court in Brooklyn that I believe, Mr. Hynes. Do they use the same procedure?

Mr. HYNES. Yes.

Mrs. MINK. I think that in order for people to understand exactly what the drug court is, we have to be able to explain how an individual is selected for the program. Some go to jail, some go to drug court. What is the definition between those two areas? Obviously it is better to be in drug court. Obviously it works better, obviously it is cheaper for the government. The question is, are there statutory steps that must be taken.

In the selection process, we have to be very careful that we are not selecting people out by various factors of discrimination. I believe it works. We went to see one in Hawaii as it is practiced. The foundations of it seem somewhat hazy, as to exactly how the program distinguishes between those that go to jail and those that don't.

Thank you very much, Mr. Chairman.

Mr. MICA. I would like to recognize the gentleman from California, Mr. Ose.

Mr. OSE. I have a couple of questions on the testimony from District Attorney Hynes. There is a phrase in here that I didn't understand on page 2. I know what the word means in normal language. I don't quite understand it in this context. It says, "The program is offered only to non-violent, predicate drug offenders for a certain punishment." What does that word mean?

Mr. HYNES. Predicate means they have been previously convicted of a sale of drugs for their own habit. If you remember the young fellow who testified before you and the rest of the committee several months ago, Fred Cohen; he was someone who had been convicted of selling drugs for his own habit. Then he got arrested again. He was a predicate offender. New York State law has a mandatory jail sentence unless I exercise discretion pre-indictment.

Mr. OSE. The second question I have, I noticed in your testimony you highlight a recidivism rate of 23 percent and a retention rate of 66 percent.

Mr. HYNES. Yes.

Mr. OSE. I am hopeful that you can explain. If I understand, the recidivism rate is someone who has been through the program and a retention rate is someone who is in the program?

Mr. HYNES. Within the first year of the program, the retention rate is 66 percent.

Mr. OSE. Retention rate meaning?

Mr. HYNES. Staying in the program.

Mr. OSE. So they are clean, have stayed in the program for a year, two-thirds of the people have complied. So one-third have not?

Mr. HYNES. Yes, which to the national average is like 12–15 percent retention rate for this population.

Mr. OSE. In terms of a non-drug court.

Mr. HYNES. For this population in non-drug court. These are the people who have hit bottom, Mr. Ose. This is their last chance.

Mr. OSE. Pre-indictment?

Mr. HYNES. Yes, sir.

Mr. OSE. The recidivism rate is people who have completed the program whether it be drug court or non-drug court and it is 23 percent?

Mr. HYNES. Our population is 23 percent for the drug treatment alternative to prison.

Mr. OSE. I think District Attorney Hynes said there is a retention rate in treatment of 50 percent and courts, 66 percent. The treatment you are referring to there, would that be private treatment?

Mr. HYNES. It is not 50 percent.

Mr. OSE. I have lost the reference. I will come back to that.

Judge Tauber, if I understand correctly, your testimony is "District Attorney Hynes very clearly says that 96 percent of the absconders are returned to court in a median time of 9 days." Your testimony says, "The failure to appear rate has dropped from 36 percent to 3 percent." So that would be consistent. You would be at 97 percent and he is at 96 percent.

Mr. HYNES. It is a different population, Congressman.

Judge TAUBER. It is a different population. I think different parameters as well.

Mr. OSE. You talk here in terms of a drug court?

Judge TAUBER. Yes, sir.

Mr. OSE. Talking about the rate at which people fail to appear. You are talking about the DTAP program where the prosecutors have control?

Mr. HYNES. These are people actually in treatment, residential treatment. The coercive part of it is if they leave the program, they are picked up.

Let me say a word about the drug court. I was not a great fan initially of the drug court. I am now convinced that the drug court is an exceptionally efficient way to do cases in my county for misdemeanors and a selected number of felonies, so we are very satisfied with the success of our drug court in Brooklyn.

Mr. OSE. I want to make clear that the appearance rate under the prosecutor-driven process is 96 percent and the appearance rate within a 9-day median under the Drug Corp is different.

Mr. HYNES. Let me try and explain. When someone leaves my program, they are in Daytop Village and are in the middle of their 15 or 20 month stay at Daytop Village. If they leave, there is a 96 percent chance they are going to be grabbed within 9 days. So 96 percent of the people who left our program are picked up within a median time of 9 days. They are in the program and they just walk off.

Mr. OSE. Those are the only questions I have, Mr. Chairman. Thank you.

Mr. MICA. I would be pleased to recognize the gentlelady from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you very much.

I am not an attorney but I was a State legislator and there was a period where we were every other day passing some kind of mandatory minimum sentence relating to drugs. Like my colleague from Hawaii, I am a bit confused about the interface between these mandatory minimum sentences and this alternative programming. Am I to understand that what really matters here is what people end up being charged with, what the indictment is, and that there is discretion there. Once there has been an indictment, if there is a mandatory minimum, there is no way around it?

Mr. HYNES. In New York state, once we have an indictment, we lose discretion.

Ms. SCHAKOWSKY. What we are talking about here is the prosecutor's discretion? Is that what enables this?

Mr. HYNES. They need our involvement in the drug court. We have to agree to it. We are a partner in the DTAP program. We totally control the process because we are dealing with a much more severe kind of population.

Under the State constitution in New York State, the district attorney is the chief law enforcement officer of the county. He or she decides who is going to be prosecuted and under what charge. Using that authority before indictment, I exercise discretion. Once we get an indictment, I have lost discretion.

Ms. Schakowsky. I understand that.

Judge TAUBER. I might add. It may not sound like a very satisfactory answer but there are 50 States and every one of them has a different statutory setup. Drug courts have managed to find ways to deal with mandatories to my knowledge in every one of them.

In some places, it is like New York where you have to move either preindictment. Washington, DC, the place where they find room to maneuver is between the time of plea and the time of sentence because once a person is sentenced, they must be sentenced

to a mandatory minimum. So they enter the person into the drug court at the time of plea and the person is not sentenced until they complete the program or flunk out.

I guess what I am suggesting is that there is flexibility in systems. We would like more flexibility from the State legislators but drug courts have been able to operate.

One of our disappointments is that perhaps we are reaching 3 or 4 percent of the eligible population throughout the United States. There are some 2 million persons placed on probation, according to the Bureau of Justice statistics for drug and alcohol offenses who, BJA determined or concluded, have a serious drug or alcohol problem. Of that, we have perhaps 250,000 involved in these programs. We would like to see drug courts expand because as they are proving themselves, it is important they have that opportunity.

Ms. SCHAKOWSKY. Let me ask you this, because I think that is an important piece of it. Who gets chosen and how does that happen? I am wondering if we have a profile of those individuals who are diverted from the usual incarceration? Is it a middle class phenomenon, are we talking also a proportionate number of people of color?

Judge TAUBER. This is my standard response; it depends on the community. In communities where such is open, let me give Oakland as an example. The persons entering the program were 80 percent African American males, because that reflected those persons being charged with possession for small amounts of drugs, typically crack-cocaine or other serious drugs. People were actually diverted under the California statute out of the regular system in California.

Ms. SCHAKOWSKY. By statute, you say?

Judge TAUBER. By statute.

Ms. SCHAKOWSKY. People who might be eligible are nonviolent.

Judge TAUBER. I can tell you book and footnote about California, that is one State. I could not do that for New York, but in California if you did not have a prior felony, did not have prior drug conviction for 5 years, and if you were not charged with an offense that involved sales or violence, you were eligible for diversion.

Hawaii, I am quite certain, has a very different setup but drug courts, the genius of them, is that they are community-based and that individual communities find what populations are appropriate. That may be very different depending on the politics, resources, and the socioeconomic background of that community.

Ms. SCHAKOWSKY. Thank you.

Mr. Hynes did you have a comment on that?

Mr. HYNES. It depends where the program fits. In Kings County, a very high percentage of our client population are Latinos, the largest population of participants are people of color. If it was in Jefferson County or Clinton County in the north country, it would be all Caucasian. The client population are drug addicts who typically come from impoverished situations, little or no education, almost no jobs and they have drifted into this lifestyle.

We eliminate people charged with violent felonies, those who have serious prior absconding records and we try and select people we believe have a real interest in turning around their lives. We

are very, very careful in the screening process. I think that is key because we are dealing with a population that has hit rock bottom.

Representative Mink was here when Fred Cohen testified before this panel. Here was a kid who for 20 years was in the gutter. He now makes $45,000 a year and pays taxes on that, has a wife and two kids but he was so bad, he used to take glasine envelopes and sniff them to try to get residue to get high. It was a tragic problem, but today he is actually the President of our drug treatment association.

Ms. SCHAKOWSKY. Thank you.

Mr. MICA. I want to thank our panelists. You bring to the Congress and to our subcommittee several alternatives to incarceration. One is the drug court program which has been successful in many jurisdictions; second, being the DTAP Program, which again does offer some alternative and both good examples of what we can do.

Unfortunately, these only address a small percentage of the population we have to deal with, but they do provide us with some positive alternatives and steps that hopefully can be replicated.

Mr. HYNES. May I close with two points? First, thank you, Congressman Mica, for having the foresight to introduce this kind of legislation. You are right, it is not an extraordinarily large population. As I said to a good friend of mine and a Member of Congress 10 years ago when he said, "what is it, a damned 100 people?" I said, "it is a damned 100 people we have never tired to cure."

We have 441 taxpayers out of that program and I am very proud of them and pleased and grateful to you, Congressman Mica, for this opportunity.

Mr. MICA. Thank you both and we look forward to working with you and hopefully we can replicate these successful programs across the country.

We will call our second panel which consists of Steven Belenko, senior research associate, National Center of Addiction and Substance Abuse, Columbia University, New York; Dr. Sally L. Satel, adjunct scholar, American Enterprise Institute here in Washington, DC; and Mr. Martin Iguchi, co-director, Drug Policy Research Center, RAND Corp., Santa Monica, CA. I am pleased to welcome all three of our witness.

If you will stand at this time to be sworn and raise your right hands. Do you solemnly swear that the testimony you are about to give before this subcommittee of Congress is the whole truth and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. MICA. The witnesses answered in the affirmative.

We will hear first from Steven Belenko, senior research associate, National Center of Addiction and Substance Abuse, Columbia University, New York. Welcome and you are recognized.

STATEMENTS OF STEVEN BELENKO, SENIOR RESEARCH ASSOCIATE, NATIONAL CENTER OF ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIVERSITY; DR. SALLY L. SATEL, M.D., ADJUNCT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC; AND MARTIN IGUCHI, CO-DIRECTOR, DRUG POLICY RESEARCH CENTER, RAND CORP., SANTA MONICA, CA

Mr. BELENKO. Thank you, Mr. Chairman.

I appreciate the opportunity to come before you this morning and talk about my research on drug courts and innovative prosecution programs.

I have been studying the impact of drugs on the justice system, including policy and programmatic responses to this problem, for some 15 years. During the past 8 years, I have had a particular interest in drug courts and have visited many around the country, studied their impacts and reviewed a number of research reports and evaluations on their effectiveness.

In addition, for the past 5 years, I have been conducting an extensive evaluation of the Kings County DTAP Program under a grant from the National Institute on Drug Abuse.

My remarks will center on two areas, one, the lessons learned thus far about the operations and effectiveness of drug courts and the potential role of prosecutorial based treatment in saving tax dollars by introducing treatment to other segments of the criminal justice population.

The first program was implemented in Dade County in 1989. The current generation of treatment drug courts has established an important presence in America's criminal court system. In many jurisdiction, drug courts have become the intervention of choice for linking drug or alcohol-involved offenders to community-based treatment and related interventions.

The key goals of drug courts are to reduce drug use and associated criminal behavior by engaging and retaining drug involved offenders in treatment and related services. Also, to concentrate expertise about drug abuse and addiction and treatment into a single courtroom under a single judge and staff, and to address other defendant needs through case management and clinical assessment.

The question of whether drug courts should be thought of as coerced treatment is an interesting one but difficult to answer. Drug courts are generally considered voluntary in that offenders generally have the right to accept or decline participation once screened for eligibility and to have their case prosecuted through regular channels.

Some drug courts also allow offenders an opportunity to opt out of the drug court after a week or two of trying it out with no loss of legal rights. However, there are some coercive elements to the drug court experience which may help to explain their success in retaining offenders.

For example, defendants may feel subtle or direct pressure to participate in drug court because of fears of the consequences of prosecution. Also the close judicial supervision and monitoring, regular drug testing, and graduated sanctions typical of drug courts may be considered coercive in their own right.

Also the immediacy of sanctions imposed in most drug courts, unlike sanctions imposed under probation or parole supervision, may increase the relevance and behavioral impact of judicial responses.

When interviewed, participants have noted the importance of the certainty, the swiftness and the predictability of the sanctions for noncompilant behaviors.

My review of drug court research is based on an article I produced in 1998 which was published in the National Drug Court Institute Review in which I reviewed about 30 existing evaluations. I recently updated that and that will be out shortly in a new issue of the National Drug Court Institute Review. I have reviewed another 30 evaluations so my remarks and assessment about drug court impacts is based on review of those 60 evaluations, as well as the GAO report from 1997 and periodic surveys of drug courts conducted by American University Drug Court Clearinghouse.

The structure and procedures in drug courts do result in closer and more frequent supervision of offenders than typically seen under standard probation or pretrial supervision. The data indicate that a number of court appearances, number of drug tests, the level of supervision and the contacts with treatment providers are substantially more frequent under drug court law than under other forms of community supervision.

The drug court model also differs in important ways from previous efforts to provide drug treatment of offenders. The various components of the criminal justice and substance abuse treatment systems work together to try and use the coercive power of the court to promote abstinence and pro social behavior, as well as treatment retention.

By comparison, the types of nonviolent drug offenders typically targeted by drug courts will often receive probation or short jail sentence with little treatment or close supervision in the community. In addition, drug courts often seek to standardize the treatment process by requiring discrete treatment phases, a minimum length of program involvement or specific requirements for the quantity and type of services. This structure offers an opportunity for the judicial officer to monitor compliance with the drug court requirements, provide rewards for advancing through different phases or participating in certain levels of treatment in a way that can be quantified. That is predictable for the participant.

Some of my key conclusions are, first of all, in terms of drug use and treatment history, there is some discussion about the type of population generally served by drug courts. As Judge Tauber pointed out, there is a lot of local variation in the target populations but trying to generalize across the country, drug courts generally serve a clientele that do have extensive histories of substance abuse, but little prior treatment.

The average age of adult drug court participants is in the early 30's, as it is in the DTAP Program, and they have been using illegal drugs for some 10 to 15 years.

In the survey conducted by the American University Clearinghouse of drug court participants, only 26 percent of the participants had been in a prior substance abuse treatment program, although 72 percent had been in jail or prison. These rates are similar for

overall rates for both treatment participation and prior incarceration found in surveys of arrestees. Similarly for surveys of probationers.

In terms of treatment retention, I think that a key impact of drug courts as well as the DTAP Program has been its ability to retain offenders in treatment. The research on drug treatment outcomes has consistently found that time in treatment is closely related to successful outcomes, including reduced relapse and reduced criminal behavior.

I estimate nationally about 60 percent of those who enter drug courts are still in treatment after 1 year, although most drug courts require a minimum program length of 1 year. The percentage of all admissions who actually graduate from drug courts is a little bit lower than that 60 percent figure. The GAO report in 1997 estimated that 48 percent of those who enter drug courts graduate. My conclusion is that is probably a little low but generally around 50 percent of those who enter drug courts would be expected to graduate.

These retention and completion rates are substantially higher than seen in studies of community based treatment programs.

In terms of drug use and criminal behavior while under drug court supervision, the existing research suggests that drug court participants have a low rate of drug use as measured by urine tests which indicates high rate of program compliance. For example, for 13 drug courts reporting test results in 1998, an average of only 10 percent of those tests were positive for illegal drugs, in contrast to drug tests of other defendants in those jurisdictions under probation supervision where the positive rate was 31 percent.

In terms of recidivism, a number of drug court evaluations have found that rearrest rates were substantially reduced while offenders are under drug court supervision.

There are probably four or five evaluations that have looked at the costs and benefit of drug courts, although they have used different measures, different time periods and it is hard to generalize. But all have found in one area or another reduced costs and the data thus far suggest that for the long term, drug court economic benefits will outweigh the costs.

The study was done by Dr. Michael Finigan in Oregon and he did find substantial local and State taxpayer savings as measured with a number of outcome measures from that drug court.

A key issue in drug courts is their effect on recidivism and public safety. The studies I have reviewed thus far, 21 of those evaluations have examined post program recidivism generally measured by rearrest and generally for a time period of 1 year after completing the drug court. Of those 21 evaluations that have also used a comparison group from which we can measure the relative impact of drug courts, 16 of those studies found that the drug court reduced rearrest for those who went through the system, looking at everyone who went into the drug court, not just those who successfully graduated. The size of that impact does vary across jurisdictions.

[The prepared statement of Mr. Belenko follows:]

STATEMENT OF STEVEN BELENKO, PH.D.

The National Center on Addiction and Substance Abuse
at Columbia University

Oversight Hearing "Drug Treatment Options for the Justice System"

United States House of Representatives
Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy, and Human Resources

April 4, 2000

Good morning Mr. Chairman, members of the Subcommittee, and Subcommittee staff. My name is Dr. Steven Belenko, and I am a senior research associate at The National Center on Addiction and Substance Abuse at Columbia University. I appreciate the opportunity to speak with you about my research on drug courts and innovative prosecution programs. I have been studying the impact of drugs on the criminal justice system, and policy and programmatic responses to this problem, for more than 15 years. For the past eight years I have had a particular interest in drug courts, and have visited many around the country, studied their impact, and reviewed numerous research reports on their effectiveness in reducing illegal drug use and crime. In addition, for the past five years I have been directing an extensive evaluation of the Brooklyn (NY) District Attorney's Drug Treatment Alternative to Prison (DTAP) program. The Honorable Charles Hynes, who created and implemented DTAP, has discussed the development and operations of that program with you this morning.

My remarks this morning will center on two areas: (1) The lessons learned about the operations and effectiveness of drug courts, and (2) the potential role of prosecutorial treatment diversion programs in saving tax dollars and reducing crime.

Drug Courts

From the first program implemented in Dade County (Miami, FL) in 1989, the current generation of treatment drug courts has established an importance presence in America's criminal court system. In many jurisdictions, drug courts have become the intervention of choice for linking drug- or alcohol-involved offenders to community-based treatment and related clinical interventions.

Although still only serving a relatively small percentage of offenders with substance abuse problems, drug courts have enjoyed considerable publicity, government and public support, and funding at all levels of government. According the Department of Justice, as of January 2000, drug courts had been implemented in 440 jurisdictions, and an additional 279 were in the planning stages. Drug courts are operating or planned in all 50 states as well as the District of Columbia, Puerto Rico, Guam, two federal jurisdictions, and 44 Native American Tribal Courts; an estimated 140,000 drug offenders have entered drug court programs since 1989.

The key goals of drug courts are to reduce drug use and associated criminal behavior by engaging and retaining drug-involved offenders in treatment and related services; to concentrate

expertise about drug cases into a single courtroom; and to address other defendant needs through clinical assessment and effective case management.

The key components of drug courts typically include:

1. judicial supervision of structured community-based treatment;
2. a dedicated courtroom reserved for drug court participants
3. timely identification of defendants in need of treatment and referral to treatment as soon as possible after arrest;
4. regular status hearings before the judicial officer to monitor treatment progress and program compliance;
5. increasing defendant accountability through a series of graduated sanctions and rewards;
6. mandatory periodic or random drug testing;
7. establishment of specific treatment program requirements, with compliance monitored by a judicial officer; and
8. dismissal of the original charges or a reduction in the severity of the sentence upon successful treatment completion

The structure and procedures of drug courts also result in closer and more frequent supervision of offenders than typically seen under the standard probation or pretrial supervision that most nonviolent drug offenders experience, especially earlier in their criminal careers. The studies and data on drug courts that I have reviewed indicate that court appearances, drug tests, supervision and treatment contacts are much more frequent under the drug court model than under other forms of community supervision.

The question of whether drug courts should be thought of as "coerced" treatment is an interesting but difficult question to answer. Drug courts are generally considered "voluntary," in that offenders have the right to decline participation and have their cases prosecuted through regular channels, and some drug courts allow an initial period during which participants can "opt out" of the program with no loss of legal rights. However, some coercive elements exist in the drug court experience. For example, defendants may feel subtle or overt pressure to participate in drug court because of fears of the consequences of prosecution. The close judicial supervision and monitoring, regular drug tests, and graduated sanctions typical of drug courts are certainly coercive elements in their own right. The immediacy of sanctions imposed in most drug courts may increase the relevance and behavioral impact of judicial responses. Drug court participants have themselves noted the importance of the certainty, swiftness, and predictability of sanctions for noncompliant behaviors.

Drug courts trace their roots to a fairly lengthy history of various mechanisms to link substance abuse treatment to the criminal justice process, with direct antecedents dating back nearly fifty years. The general concept of dedicating specified courtrooms solely to drug cases is not new, and special drug case courtrooms operated both in Chicago and New York City in the early 1950s. In the early 1970s, when heroin was the primary drug of abuse among offenders, New York City set up special " Narcotics Courts," in response to the passing of the punitive "Rockefeller" drug laws. Such narcotics courts were designed to help ameliorate the anticipated impact on court dockets of an influx of new drug cases and an increased demand for trials expected to be generated by the new laws. For the most part, however, these earlier efforts provided only limited access to drug treatment for offenders, reflecting in part that they were generally designed to process drug cases more efficiently, not to treat drug offenders for their addiction problems.

Other methods and programs have been tried over the past 20 years to link offenders to drug treatment at various points of the criminal justice process. Some drug courts evolved from existing programs or efforts to engage defendants in treatment, such as Treatment Alternatives to Street Crime (TASC) program, diversion programs, conditions of pretrial release, conditions of probation or in conjunction with intermediate sanctions. But the failure to provide offenders with treatment services and the difficulty of offenders getting treatment services through the referral system has contributed to the criminal justice system's previous lack of faith in treatment as an option for offenders. Moreover, these earlier efforts were often fragmented, inconsistently or inappropriately used or not viewed by the criminal justice system as sufficiently effective. Supervision of treatment often rested on several agencies, and consequently it was difficult to monitor treatment progress or compliance with court-imposed conditions.

But the drug court model differs in important ways from previous efforts to provide drug treatment to offenders. In the drug court model, the various components of the criminal justice and substance abuse treatment systems work together to try and use the coercive power of the court to promote abstinence and prosocial behavior and treatment retention. By comparison, for the types of non-violent drug offenders generally targeted by drug courts, the typical adjudication process would result in a probation or short jail sentence, with little treatment or close community supervision. In addition, drug courts often seek to standardize the treatment process by requiring discrete treatment phases, a minimum length of program involvement, or specific requirements for the quantity and type of services.

Most drug courts require at least one year of participation, and incorporate several treatment phases. Phase I typically includes assessment, orientation, development of a treatment plan and treatment readiness, and generally ranges between 30 and 90 days. Phase II is the primary treatment phase and typically lasts about six months. The final Phase III includes relapse prevention, discharge planning, vocational and educational training, and lasts between 2 and 4 months. The offender does not have to be placed on a "waiting list" for available services, but has immediate access to treatment. Defendants who complete the drug court program either have their charges dismissed (in a diversion or pre-sentence model) or their probation sentences reduced (in a post-sentence model).

The drug court model incorporates a more proactive role for the judge, who in addition to presiding over the legal and procedural issues of the case, functions as a reinforcer of positive client behavior. Although the judge is the central player in the program, most drug courts seek to function as a team in which prosecutors, defense attorneys and counselors work together to help offenders overcome their drug problems and resolve other issues relating to work, finances and family. Dr. Sally Satel has noted how the personality and role of the judge is often seen as being a key factor in the success of a drug court. Unlike the traditional courtroom role in overseeing court-mandated treatment, the drug court judge plays a much more direct role in monitoring an offender's treatment progress and compliance.

In the remainder of this section, I summarize the key conclusions about drug court operations and effectiveness gleaned from my review of some 60 drug court evaluations.

Key Findings from Drug Court Research

Drug Use and Treatment Histories

Drug courts are serving a clientele that has had extensive histories of substance abuse, but little prior treatment. The average age of adult drug court participants is the early 30s, and they have been using illegal drugs for 10-15 years. In a survey conducted by the Drug Court Clearinghouse and Technical Assistance Project at American University, only 26% of drug court clients had been in prior substance abuse treatment, although 72% had been in jail or prison. These rates are similar to overall rates found for arrestees: according to data from the U.S. Department of Justice Drug Use Forecasting system, only 24% of adult felony arrestees had ever been in drug treatment, including about 26% of those arrested for felony drug sale or possession.

Drugs of choice vary by court and region of the country. For some drug courts on the West Coast, methamphetamine use is common, while in most drug courts in the east or south cocaine and heroin are the most common drugs of abuse. Ideally, treatment services should be tailored to the individual substance use problem and treatment needs.

Retention in Treatment

Research on drug treatment outcomes has consistently found that a longer time in treatment is associated with better outcomes. Although data limitations and jurisdictional differences make it difficult to accurately calculate overall drug court retention and completion rates, I estimate that nationally about 60% of those who enter drug courts were still in treatment (primarily outpatient) after one year. Although most drug courts require a minimum program length of one year, the percentage of all admissions that actually graduate from drug court is somewhat lower than the percentage still in the program after one year. The 1997 General Accounting Office report on drug courts estimated a minimum 48% average program completion or graduation rate for those that enter drug court; this figure does not include those who were still active in the drug court, so actual graduation rates are likely higher. These retention and completion rates are much higher than generally found in community-based treatment programs. For example, in a recent national treatment outcomes study Dr. Dwayne Simpson and his colleagues at Texas Christian University found that only half of those admitted to outpatient drug-free programs stayed three months or longer.

Elements of the drug court model that may increase retention in treatment (such as graduated sanctions and rewards, judicial supervision, and acceptance of relapse) have not been studied extensively but merit further research.

One drug court evaluation illustrates how length of time in treatment may affect outcomes. For the Multnomah County (Portland, OR) drug court Dr. Michael Finigan's evaluation found that the longer time in treatment the lower the post-program recidivism. This finding is consistent with general findings in the treatment outcome literature and suggests that the positive impacts of drug courts may be increased by strategies and procedures that increase the length of participation in treatment.

In addition, many drug courts recognize that most drug-involved offenders have other service needs in addition to treatment. These include physical and mental health problems, limited educational and employment histories, and housing needs. Most of the drug court evaluations that have examined the delivery of ancillary non-treatment services found that such services were made available and accessed by drug court clients. However, specific data on the percentage of clients who have accessed particular services is generally not available, but would be important to document in future evaluations.

Drug use and Criminal Behavior under Drug Court Supervision

Drug use. A growing number of drug court evaluations are now reporting urinalysis test data. Generally, drug court participants have a low rate of positive drug tests, indicating high rates of program compliance in terms of sobriety. For the 13 courts reporting urinalysis test results in a 1998 drug court survey, an average of 10% of the tests were positive for illegal drugs. In contrast, in the same jurisdictions the average percentage of positive tests for similar defendants not in the drug court but under probation supervision was 31%.

Recidivism. A number of drug court evaluations have found that rearrest rates are low while participants were in the drug court program. Based on several evaluations, in-program recidivism appears to be quite low for drug court graduates. Not surprisingly, given that a new arrest is often a trigger for program termination, in-program rearrest rates are higher for program failures.

Sanctions and Incentives and the Judicial Role

An important and unique aspect of drug courts is the role played by the judge. In the traditional criminal court, the judge plays a relatively non-involved part in the proceedings, ruling on matters of law, overseeing the courtroom, and handing down convictions and sentences. With the exception of the formal guilty plea and the sentencing, there is typically little interaction between the judge and the defendant. In contrast, the drug court judge plays the key role in the proceedings and engages directly in conversation with the participant. In addition, although the traditional judge's role in criminal cases is to punish offenders, the drug court judge plays a very untraditional role of also rewarding and praising participants when they do well or achieve specific goals. This combination of sanctions and rewards that typify most drug courts may be another important explanation for their high retention rates.

There is some evidence that drug court participants also view the judge's role as a key component of the drug court. In a 1997 survey of a nonrepresentative sample of drug court participants, 75% said that the fact that a judge monitors their treatment progress was a very important difference between the drug court and prior treatment program experience, 82% cited the possibility of sanctions for noncompliance as a very important difference, and 70% of respondents thought that the opportunity to talk about their progress and problems with a judge was a "very important" factor in keeping them in the program.

Basic psychological principles of punishment and rewards suggest the potential power of these actions in shaping and changing participant behavior. A large body of behavioral psychology research finds that a variable schedule of positive and negative reinforcement (i.e. sanctions and rewards) is the most powerful and lasting shaper of new behaviors. Punishment alone is known to be a poor method of changing behaviors. The more informal and client-centered atmosphere of the drug court allows these processes to emerge and take shape much more than in a traditional courtroom setting.

New data are beginning to emerge on the use of sanctions and incentives in the drug court setting. This information is descriptive, enumerating the number and type of sanctions and rewards imposed. We still know little about the impacts of various sanctions and rewards on drug court client compliance or retention.

Economic costs and benefits

One important empirical question about drug courts is whether the costs of operating such programs are lower than the economic benefits or avoided costs that accrue because incarceration time is reduced, or because drug treatment reduces the likelihood of relapse and recidivism. Several studies on drug treatment in other criminal justice settings have concluded that investments in treatment generate substantial net economic benefits relative to their costs.

Although using varying methodologies and data sources, drug court evaluations that have examined economic costs and benefits generally conclude that drug courts generate savings in incarceration costs. In addition, cost savings have been found in probation supervision, police overtime and other criminal justice system costs. Dr. Michael Finigan's study of the Multnomah County (OR), employing a comprehensive methodology and multiple outcome measures, estimated substantial long-term cost savings to the county and state that were attributable to that drug court.

Post-program recidivism

Most studies that have compared post-program recidivism for drug court participants to a comparison group of drug offenders have found lower rearrest rates for drug court clients. All studies have found much lower recidivism rates for those who graduate from drug courts. Out of a total of 21 drug court evaluations that I have reviewed that examined post-program recidivism with a comparison group, 16 have found that the drug court reduced recidivism, and 5 found no difference in recidivism between drug court participants and a comparison group. The size of the reduction in recidivism varies across studies. The different results may depend on the comparison group used, the length of the follow-up period, the recidivism measure, differences in the drug court structure or quality of treatment services, and variations in the target population served.

Summary

In summary, drug courts have proliferated rapidly over the past few years. They appear to be an important tool in the response to drug-related crime. There may also be important ancillary benefits of drug court programs that are relatively untapped. Given the characteristics of their target populations, drug courts can provide an important public health intervention role in the criminal justice system. The drug court screening, assessment, and referral process provides an opportunity to identify participants' health problems and link them to appropriate interventions. The close supervision and case management structure typical of drug courts can help to assure access to health services and follow-through on treatment and medications. Through interagency planning, cross-training, drug treatment access, case management, and close client supervision, drug courts may play an important role in reducing HIV risks, for example. Comprehensive health assessments, access to referral networks, appropriate referrals, and follow-up with participants to assure compliance with health care regimens are all important dimensions of the effectiveness of drug court-based health services, and keys to better long-term outcomes for drug-involved offenders.

The drug court field's commitment to research and evaluation and the Department of Justice's investment in evaluations for its drug court grantees are beginning to reap dividends. There is now a growing body of data on drug court operations and client characteristics, as well as a broad array of descriptive information about drug court implementations, operational problems and their solutions, and modifications that have taken place in drug court procedures and operations. These evaluations now provide considerable information about how drug courts are implemented, what types of clients are served, what services are received, how clients perform while in the program, and how recidivism is affected by drug court participation. Such information is extremely important in educating the community, policymakers and the media about the operations and impacts of drug court programs across the country.

Drug Treatment Alternative to Prison (DTAP) Program

In addition to drug courts, a growing number of prosecutors are now implementing programs that divert drug-involved offenders into treatment. Recognizing that incarceration or punishment without treatment is an incomplete response to drug-related crime and is unlikely to reduce such crime or illegal drug use in the long run, innovative programs such as the Drug Treatment Alternative to Prison (DTAP) program are being implemented and studied in a number of jurisdictions.

The Brooklyn Drug Treatment Alternative to Prison (DTAP) program was established by the Kings County (Brooklyn, NY) District Attorney Charles J. Hynes in 1990 to divert into treatment non-violent felony offenders with one or more prior felony convictions and a documented history of drug abuse. The original target population was non-violent repeat felons arrested for felony drug sale who, under New York State's Second Felony Offender Law, face a mandatory prison sentence if indicted.

Defendants accepted into DTAP have their sentences deferred while undergoing 15-24 months of intensive residential drug treatment in one of several therapeutic community programs. Those who successfully complete treatment are returned to court to have their charges dismissed. Failure to complete treatment results in prosecution on the original charges, and in most case, conviction and sentencing to state prison.

Since the inception of DTAP in October 1990, 3,617 non-violent felony offenders have been screened, of whom 2,521 (70 percent) have been rejected or refused DTAP, and 1,096 (30 percent) placed into treatment. Of those accepted by the program, 406 (37 percent) have graduated, and 232 (21 percent) were still in treatment as of October 1999.

In January 1998, DTAP expanded its target population to include observation sales and nonviolent property offenses motivated by drug addiction. DTAP shifted from a deferred prosecution to a deferred sentencing model. Now all defendants must plead to a felony prior to acceptance by the program. Another major change is that DTAP now routinely considers readmitting appropriate participants (those with a good prospect of re-engaging in the therapeutic process) into treatment.

To date, DTAP has produced a one-year retention rate of 66 percent, i.e. two-thirds of those who were accepted into the program remained in treatment for at least a year. This retention rate is considerably higher than rates found in national studies of residential treatment. For example, in one major review of research on residential therapeutic community treatment programs one-year retention ranged from 10 to 30%. For those admitted under the deferred prosecution model, the rate of retention at the twelfth month was 64%, but the rate for those admitted under the newer deferred sentencing model rose to 74%.

Recidivism data analyzed by the Kings County District Attorney's office indicate that successful DTAP program participation lowers rearrest rates. Rearrest rates for three years post-DTAP or post-sentencing were compared for 184 DTAP graduates and 215 drug offenders who met DTAP's initial eligibility criteria but did not participate in the program. Forty-seven percent of the comparison group were rearrested during the 3-year follow-up period, while only 23 percent of DTAP completers were rearrested.

Along with several colleagues, I have been conducting an extensive evaluation of the DTAP program for the past five years, under a grant from the National Institute on Drug Abuse. The evaluation is examining the impact of DTAP on participants' drug use, criminal activity, social stability, HIV risk behaviors, and other outcomes. In addition, we are assessing the

economic costs and benefits of DTAP, and are studying the role of legal pressure in retaining offenders in treatment.

The evaluation is addressing the following research questions:

(1) Do drug offenders diverted into residential treatment have more favorable post-treatment outcomes than similar defendants sentenced to prison?

(2) Do the economic benefits of DTAP participation exceed the costs of the program?

(3) Does DTAP improve treatment retention compared to similar offenders referred by other criminal justice sources? Are there specific elements that make DTAP uniquely coercive?

To answer these questions, our evaluation includes three substudies: (1) impact of DTAP participation on client outcomes, (2) benefit-cost analysis, and (3) elements of legal coercion impacting on retention and outcomes. We are employing a longitudinal quasi-experimental design in which retention, treatment outcomes, and program costs are being compared for various samples of drug offenders:

For the impact study the experimental group is comprised of 150 second felony offenders arrested in Brooklyn, New York during 1995 and 1996, who were diverted from prison to the DTAP program. The comparison group consists of 130 second felony offenders sentenced to prison from other boroughs in New York City, matched to the DTAP group on gender, age, race, penal law conviction charge, sentence, criminal history, drug use and other criteria used for assessing suitability for therapeutic community treatment. Comparisons were sentenced to prison terms equal to those that DTAP respondents would have received if they had not been diverted to treatment (range: 18-36 months).

For the legal coercion substudy the same sample of 150 DTAP participants is being compared to a matched comparison sample of 200 clients from the same treatment programs, referred from other criminal justice sources.

As of June 1999, 91 of the 150 experimental subjects (61%) graduated from DTAP, and 59 (39%) dropped out prematurely. Treatment Completers averaged 22 months of treatment, while Treatment Dropouts averaged 9 months of treatment and 22 months of prison time after facing the original charges following dropout. Prison Comparisons averaged 27 months of prison time for the comparable conviction.

Although our data collection and data analyses are still underway, preliminary results suggest that answers to the first research question will be in the affirmative. Treatment retention in the research sample is similar to that found for the DTAP program overall. Based on preliminary six-month outcomes, in nearly all measured areas – family, social, vocational, financial, substance use, legal, physical and psychological health, and sexual behavior relating to HIV-risk – Treatment Completers revealed significant improvement over Treatment Dropouts and Prison Comparisons. Our analyses of recidivism data for the research samples show findings consistent with those reported by Kings County District Attorney researchers. For an 18-month follow-up period from treatment completion or release from prison, 37% of DTAP experimental subjects had been rearrested, in contrast to 54% of those in the comparison sample.

Conclusions

The enforcement of anti-drug laws and the consequences of drug abuse and addiction have impacted the nation's criminal justice system in profound ways over the past 25 years. Police departments and other law enforcement agencies have paid increasing attention to drug crimes, legislatures have passed more and more punitive laws against the use and sale of illegal

drugs, and access to treatment has been limited for those subpopulations of drug users who are most likely to be targeted by the criminal justice system for drug-related offenses. As a result, burgeoning numbers of drug offenders have flooded jails and prisons, and court and probation caseloads have mushroomed.

Yet, despite abundant research demonstrating that drug treatment can significantly reduce drug use and related criminal activity, access to treatment is typically quite limited for criminal offenders relative to the need. This is confirmed by data from the national Arrestee Drug Abuse Monitoring system, surveys of offenders on probation, and data from prison and jail systems. For example, only 12% of probationers who had ever used drugs were currently in a treatment program when surveyed, and although an estimated 75% of state prison inmates are in need of substance abuse treatment, fewer than 20% actually receive such treatment. An even smaller proportion receives the intensive and longer-term treatment that many inmates need.

The lack of treatment opportunity for offenders has important implications. Although some offenders can overcome their drug problems without treatment, are able to obtain treatment on their own, or age out of drug abuse, most have difficulty escaping from the cycle of drug abuse and crime without formal interventions imposed by the criminal justice system. Offenders tend to be from communities and families that have limited resources or insurance with which to access treatment on their own.

Another problem is that aside from a few specialized programs such as drug courts and prosecutorial diversion programs, the drug abuse problems of offenders are rarely assessed until sentencing. Probation and parole departments and correctional systems may screen and assess for substance abuse problems, and judges may order treatment as a condition of probation, but few actually receive such treatment. Fewer still receive the long-term treatment and access to other services that this population tends to need.

My research on substance abuse and the criminal justice system indicates that within this overall context, drug courts and programs such as DTAP offer significant potential to effectively engage offenders into long-term treatment and related services. I believe that encouraging and expanding investments in court-monitored treatment models, and continuing to study their impacts, will yield a substantial reduction in crime and drug use, and substantial reduction in taxpayer costs. Compared with the enormous economic and social costs of building and operating the jails and prisons that house hundreds of thousands of offenders with substance abuse and addiction problems, programs such as drug courts and DTAP are likely to result in a greater impact for much less money.

Mr. MICA. Thank you for your testimony.

We will now recognize Dr. Satel.

Dr. SATEL. Thank you, Mr. Chairman.

I am also a staff psychiatrist at a local substance abuse clinic, and worked in the D.C. Drug Court a few years ago.

I was asked to talk to you today about the clinical aspects of mandated treatment and why it works. It certainly does work as volumes of data can confirm. How can this be? How can it be that drug abusers, many of whom actually have little interest in going into the treatment—that is something you don't hear a lot about but many of these folks are not interested in treatment at first. They are interested in either avoiding the mark on their record or avoiding potential jail or probation. That is why they choose it. So how can people who don't have that much interest in treatment benefit from it? How is it that drug abusers can respond when they are told by the criminal justice system that they either participate in this program or something bad will happen to them, they will either go to jail or get a record?

A lot of people can't believe that addicts who enter treatment unwillingly or halfheartedly can still benefit as much or more than addicts who show up freely at a clinic and ask to be admitted. This reality forces us to rethink one of the most trusted fictions in drug treatment; that a person has to want to get better in order to benefit from treatment. That is the fiction that drug courts and other forms of mandated treatment put to rest.

The main reason that mandated treatment works is that it keeps people in longer. You have heard that before. Retention is key, the longer one stays, the better one does, the better health, the less drug use, the less crime, the more employment. Addicts who are levered into treatment do tend to stay longer. This is for two reasons.

First, they stay longer because as I said before, the alternative in their eyes can be worse, but later because they really do see the benefits of treatment at the work programs they participate in or the educational programs which do help them feel more confident and more encouraged about their future. They feel physically better and they often get reabsorbed into the warmth of their families, something they have been estranged from for quite a while.

I have introduced dozens of drug court patients and not all, but a lot of them are enthusiastic from day one, but many of them are not. One might say they weren't happy campers when they came into the program but the longer they stayed, the rehabilitation made sense to them. In other words, they stay at first because they have to, but ultimately they complete it, most of them, about 50 to 60 percent, because they want to.

Ultimately, without some sort of leverage, the standard dropout rate is very large. We have heard this already and refer to it as the retention deficit disorder. About half drop out in the first 3 months and at the end of 1 year, between 1 and 10 and 1 and 20 remain.

When you think about the psychology of addiction, these dropout rates make perfect sense. Residents who enter a therapeutic community may rebel against the rigid structure and the deprivation of getting high. A lot of addicts are very ambivalent about giving

up drugs, as destructive as they have been. There is a powerful psychological force pulling them back to the street.

Even patients with strong motivation make experience flagging resolve or intense drug cravings or they feel better and think they either can handle life drug free or that they can handle their drugs. Either way, they leave. Self discipline, as you know, is not a strong suit of this population. Again, when mandated to residential or community treatment, the patient can't succumb to these pressures and bolt without consequences.

In summary, these observations and the objective data that support them tell us some very important things. First, they expose two myths about addiction. The first is that in order to benefit from treatment, all patients have to want it. Second, to benefit from treatment, a patient has to hit bottom. We can catch people before they hit bottom and hopefully you do because otherwise, there are diseases to catch and overdoses to be suffered.

Second, for treatment to work, patients have to stay in it and one of the best ways to get hard core addicts to stay is through leverage. As a clinician, I am certainly happy for all the leverage I can get. It is very good to have an outsider like a judge calling the shots with swift and certain consequences so that I don't wait my time getting caught up in negotiations with patients about the rules of compliance. The rules are spelled out, and my job is to work collaboratively with the patient to help him conform and progress.

When drug courts work well, they really represent a marriage between the so-called moral and medical models of addiction. The moral model is punishment, sanctions, and that drug users should be held accountable with no assistance. The medical model, on the other hand, is all help with no expectation of accountability for the patient. I reject both of them out right.

We know that neither of these alone are especially useful. In other words, addicts who are incarcerated frequently relapse once they are out of jail, but that hard core patients who enter treatment 1 day are very likely to bolt the next. Together the moral and medical elements complement each other for an optimal chance to help addicted men and women.

Thank you.

[The prepared statement of Dr. Satel follows:]

Drug Court Hearing

Before the House Committee on Government Reform

Subcommittee on Criminal Justice, Drug Policy and Human Resources

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by

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The Virtues of Coercion in the Treatment of Addiction

Background

The purpose of my testimony is to describe the principals, mechanism and benefits of mandated substance abuse treatment. The treatment-plus-surveillance model has been used successfully in a number of domains; drug courts are only one example.

No matter where one resides on the drug policy spectrum, from prohibitionist/status quo to liberalization, there is general agreement that many drug

addicts need drug treatment if they are to lead productive and satisfying lives. Yet the most promising way-- perhaps the only way-- to put enough addicts into treatment for long enough to make a difference entails some measure of coercion. This is a proposition massively supported by the empirical data on drug treatment programs, yet it runs counter to some of today's most powerful political and cultural currents.

Data consistently show that treatment, when completed, is quite effective. Indeed, during even brief exposures to treatment, almost all addicts will use fewer drugs and commit less crime than they otherwise would, which means that almost any treatment produces benefits in excess of its cost. But most addicts, given a choice, will not enter a treatment program at all. Those addicts who do enter a program rarely complete it. About half drop out in the first three months, and 80 to 90 percent have left by the end of the first year. Among such dropouts, relapse within a year is the rule.

In short, if treatment is to fulfill its considerable promise as a key component of drug control policy, whether strict or permissive, addicts must not only enter treatment but stay the course and "graduate." And if they are to do so, most will need some incentives that can properly be considered coercion.

In the context of treatment, the term coercion-- used more or less interchangeably with "compulsory treatment," "mandated treatment," "involuntary treatment," "legal pressure into treatment," "involuntary treatment," and "criminal justice referral to treatment"-- refers to an array of strategies that shape behavior by responding to specific actions with external pressure and predictable consequences.

Coercive drug treatment strategies are already common. Both the criminal justice system and the workplace, for example, have proved to be excellent venues for identifying individuals with drug problems, then exerting leverage, from risk of jail to threat of job loss, to provide powerful incentives to start and stay in treatment. Moreover, evidence shows that addicts who get treatment through court order or employer mandates benefit as much as, and sometimes more than, their counterparts who enter treatment voluntarily.

In these contexts, "coercion" does not mean force. It means forcing a choice on the individual: stop using drugs or lose your job, stop using drugs or go to jail... or to mandated treatment. With the aid of coercion, substance abusers can be rescued earlier in their "careers" of abuse, at a time when intervention can produce greater lifetime benefits. With coercion, more substance abusers will enter treatment than would enroll voluntarily, and those that enroll will enjoy an increased likelihood of success.

Clinical Reality: High Rates of Drop-Out

To illustrate the clinical realities of treatment, consider the therapeutic community. Modern therapeutic communities immerse patients in a comprehensive 18-to-24-month treatment regimen built around the philosophy that the addict's primary problem is not the drug he abuses but the addict himself. Though psychiatric orthodoxy holds that addiction is a discrete, self-contained "disease," the therapeutic community's approach recognizes drug abuse as a symptom of a deeper personal

disturbance. The strategy for rehabilitation is to transform the destructive patterns of feeling, thinking, and acting that predispose a person to use drugs.

In this effort, the primary "therapist" is the community itself, not only peers but staff members, some of whom are graduates of a program themselves and can serve as role models. The dynamic is mutual self-help; residents continually reinforce, for each other, the expectations and rules of the community. For meeting community expectations, residents win rewards-- privileges like weekend passes or increasing responsibility, culminating in leadership roles. If a resident defies the rules, he or she loses privileges and must perform the least desirable chores. All residents must work-- above all so that they learn to accept authority and supervision, an ability vital to their future success in the work force.

Researcher George De Leon has identified three stages in a resident's attitude towards such communities (1):

(1) compliance: adherence to rules simply to avoid negative consequences such as disciplinary action, discharge from the program, or reincarceration;

(2) conformity: adherence to the recovery community's norms in order to avoid loss of approval or disaffiliation;

(3) commitment: development of a personal determination to change destructive attitudes and behaviors.

Those who negotiate the commitment stage have excellent outcomes. De Leon, in a long-term follow-up study of addicts admitted to Phoenix House, found that after five to seven years, 90 percent of those who had graduated were employed and crime-free, while 70 percent were drug-free. (2)

But the graduates constituted only 20 percent of De Leon's sample. Generally, half of voluntarily committed patients leave therapeutic communities prematurely within the first 90 days, generally considered to be the threshold at which individuals form an independent commitment to a treatment program. Perhaps one in five to 10 fully completes a program. (3)

Why drop out? These dropout rates are not hard to understand. In the early months of a program, residents of a therapeutic community often rebel against the rigid structure, loss of status they enjoyed on the street, and deprivation of getting high. Ambivalence about relinquishing drugs is a powerful psychological force pulling patients back to the street. Even patients with strong motivation experience flagging resolve, momentary disillusionment, or intense cravings. If a patient succumbs to these pressures, he or she may have gained some benefit from even the brief exposure to treatment but is at high risk for relapse into drug use and crime.

De Leon therefore sees legal pressure as the initial force that can literally get patients through the door into treatment and keep them there until they internalize the values and goals of recovery. Coercion alone can not do the job: One researcher put it that "if contact with therapy does not bring its own rewards, the potency of coercion will decline precipitously, and could ultimately work against treatment goals." (12) But the threat of consequences like incarceration, the loss of a job, or some other aversive event can sustain an ambivalent or flatly resistant patient during the early months of treatment until those rewards-- newly learned skills, a transformed self-

concept, social maturation, and optimism about the future-- ultimately inspire him or her to change.

Thus it is of interest that in De Leon's Phoenix House sample, it did not matter statistically to a patient's chances of "graduating" whether he or she had enrolled voluntarily or been mandated to treatment. This similarity did not mean, in De Leon's view, that compelled treatment made no difference; it was the opposite. The compelled patients began with worse prognoses, because of their legal involvement and their higher incidence of antisocial personality disorder and low motivation. (4,5) Counteracting these disadvantages, though, was the fact that individuals who had court cases pending or had been legally referred to the community spent, on average, more days in treatment than voluntary patients did. (6) The relatively bad prognosis was made up for by more treatment days. "Retention in treatment," De Leon therefore concluded, "is the best predictor of outcome, and legal referral is a consistent predictor of retention."

Large Scale Studies Support Leverage for Retention

The first evaluation of this network of community-based programs began in 1968 when the National Institute of Mental Health funded a proposal by Saul B. Selis, director of the Institute of Behavioral Research at Texas Christian University, for the Drug Abuse Reporting Project (DARP). Data collection began in 1969 and lasted four years, following about 44,000 patients enrolled in 52 federally funded programs. The project followed subgroups for five and 12 years following discharge from treatment.

In 1974, the Institute transferred control of the project to the newly created National Institute on Drug Abuse (NIDA). NIDA subsequently funded two more large studies, the Treatment Outcome Prospective Study (TOPS), which followed 12,000 patients who entered treatment between 1979 and 1981, and the Drug Abuse Treatment Outcome Study (DATOS), which followed 11,000 patients who entered between 1991 and 1993. More recently another federal agency, the Center for Substance Abuse Treatment, undertook the National Treatment Improvement and Evaluation Study, of 4,400 patients who entered the project between 1993 and 1995.

Taken together, these studies assessed roughly 70,000 patients, of whom 40 to 50 percent were court-referred or otherwise mandated to residential and outpatient treatment programs. (7)

Two major findings emerged from these huge evaluations. The first was that the length of time a patient spent in treatment was a reliable predictor of his or her post-treatment performance. Beyond a 90-day threshold, treatment outcomes improved in direct relationship to the length of time spent in treatment, with one year generally found to be the minimum effective duration of treatment. (8-10)

The second major finding was that coerced patients tended to stay longer. (On this second point, DARP was an exception, finding no correlation between criminal justice status and either time spent in treatment or improvement. One can say only that DARP's compelled patients stayed as long as , and did no worse than, voluntary patients.)

To evaluate these findings, it is important to know whether addicts who entered treatment under legal coercion were meaningfully different from other patients. The findings from these studies are mixed. Some show that legally coerced addicts had a relatively unfavorable pre-admission profile-- more crime and gang involvement, more drug use, worse employment records-- that their non-coerced counterparts. Other studies detected little difference other than the particular offense that triggered the mandate to treatment. (11,12)

In the DARP study, the baseline characteristics of voluntary and legally referred patients were similar. Because the subjects were relatively homogeneous on these dimensions, being primarily young, male, inner-city "street addicts," more than 80 percent with at least one previous arrests and over half previously incarcerated, the authors speculate that legal status was unlikely to have been a very discriminating variable.

The TOPS study, by contrast, discovered some differences. True, legally mandated and voluntary patients had similar drug use patterns, previous criminal justice involvement, and number of prior treatment episodes. But the legally mandated patients were younger than their voluntary counterparts and more likely to be male. When researchers looked specifically at patients who reported that the criminal justice system was the primary source of their referral to treatment, they found that these legal referrals were not only younger but used mainly alcohol and marijuana rather than "harder" drugs. The authors speculate that the legally mandated patients were "caught" earlier in their careers, that they were incarcerated too recently to have re-established their habits, or both.

Though the studies do not present a consistent picture of pretreatment characteristics of legally mandated patients, they make it reasonable to conclude that even legally coerced addicts having relatively unfavorable prognoses can benefit from treatment as much as voluntary patients do, since the latter often remain in treatment for a shorter period. (13)

A 1990 report from the Institute of Medicine summarized that "contrary to earlier fears among clinicians, criminal justice pressure does not seem to vitiate treatment effectiveness, and it probably improves retention." (14) Thus, while there is conflicting evidence on whether a legal mandate brings individuals into treatment earlier, coercion can be almost surely be credited with derailing many an addiction career once individuals have been brought into treatment. (15,16)

Of special significance, in light of the importance of length of treatment, is the fact that all four national outcomes studies showed high rates of attrition among patients, with half dropping out inside of 90 days. For these early dropouts, the benefits of treatment disappeared within the year. With substantial, durable change rarely occurring in less than a year or two of treatment, the high dropout rate makes retaining patients in treatment a pressing challenge.

Social Contracting

Contracting confers advantages on individuals when they manifest a desired behavior and penalizes them for violating expectations. For instance, addiction-impaired doctors, nurses, lawyers, and pilots may be allowed to keep their jobs or licenses "in exchange" for abstaining from illicit drugs or problem alcohol use under the close monitoring of a state professional society. Recall the public service announcement, "Help an Addict: Threaten to Fire Him," made popular in the late 1980s by the Partnership for a Drug Free America. Employers who follow that directive have established Employee Assistance Programs providing treatment for workers. With good effect, the military threatens drug and alcohol abusing soldiers with dishonorable discharges unless they abstain.

Most addicts admit being pressured into treatment by external forces such as health, employment, social relationships, financial conflicts, and emotional disturbances. Researchers estimate that only a small minority of addicts in treatment enrolled solely on personal initiative, unpressured by others. (17-19) Thus the therapeutic potential of contracting, for job security or other social opportunities, is considerable.

Employee Assistance Programs: These programs were first established as early as the 1940s by employers concerned about the impact of employee alcoholism on workplace safety and productivity. The Drug Free Workplace Act of 1988 encouraged further expansion; and now, according to the Employee Assistance Professionals Association, there are some 20,000 EAPs nationwide. Four out of five Fortune 500 companies have one. From 20 to 60 percent of the EAP caseload is provided by mandatory referrals to treatment as an alternative to dismissal from work. (20)

Evidence suggests that individuals mandated to treatment via EAPs are as likely as voluntary participants, perhaps more likely, to profit from workplace-centered drug and alcohol treatment. In a study of industrial alcohol policy, Beaumont and Allsop found that workers mandated to treatment had better outcomes than those who were self-referred. (21) The authors note that workers' age and length of service were positively correlated with both mandatory referral and improvement, interpreting these connections to mean that older workers felt a greater personal professional investment in their jobs and thus responded more powerfully to the threat of job loss.

Walsh and colleagues conducted a randomized trial of treatment options for alcohol-abusing workers. (22) They assigned workers to one of three rehabilitation regimes: compulsory three-week inpatient treatment, compulsory attendance at Alcoholics Anonymous for a year, and a choice among options. During a two-year follow-up period, all groups showed comparable improvement in job performance. However, individuals participating in the most restrictive option, inpatient treatment, were significantly less likely than the others to relapse.

Researchers at the University of Pennsylvania made a similar study of 304 transportation and city service union members in Philadelphia. (23) One group, of 111 individuals, was referred to the union's EAP because of positive urine tests during random screening at the worksite; another group of 103 was self-referred. For the first, coerced, group, failure to abide by the terms of the evaluation and referral procedures was grounds for dismissal. Though most of these coerced individuals were "resistant to entering any treatment setting," all attended treatment. The level of

verification in the study was high: There were urine tests, self-reports of earnings were checked against pay stubs, and self-reported criminal convictions were checked against arrest records.

The researchers found that coerced individuals were more likely to complete a course of treatment than were self-referred workers. 77 percent of the coerced workers in inpatient care and 74 of coerced workers in outpatient counseling finished. Comparable figures for voluntary workers were 61 percent and 60 percent. At a six-month follow-up, 92 percent of all participating workers were re-interviewed; coerced and voluntary patients showed similar levels of improvement. "This is interesting," the authors note, "in that many clinicians feel strongly that intrinsic motivation is a prerequisite for engagement and improvement. . . . [F]or the participants in the study, the coercive referral condition did not hinder the chances for successful treatment."

Drug Courts

For state of the art data on outcome research, please read the testimony of fellow panelist Dr. Steven Belenko, criminologist with the Center for Addiction and Substance Abuse.

The Public's Resistance to Coercion

Coercive strategies for drug treatment range from the least intrusive– social contracting, in which individuals are simply given incentives to behave in certain ways- - to the most restrictive, as with forced treatment and confinement in the face of life-threatening behavior. No matter where on this continuum a particular coercive strategy lies, however, it has met with significant resistance.

(1) One source of this resistance is the healthy reluctance we all feel to curtail anyone's personal autonomy. Political scientist James Q. Wilson has observed that this reluctance sometimes leads us to insist on the same freedom for others that we would for ourselves, even when the others in question have great difficulty in making use of such freedom.

(2) Many clinicians voice another objection to coercive strategies: They believe, mistakenly, (a) that a patient must desire drug treatment in order to benefit from it, and (b) that he must "hit bottom" to benefit from treatment.

(3) Another source of resistance is the current medicalization of addiction, the most recent round in the century-long debate over whether drug abuse should be treated on the "medical model" or the "moral model." Thus the National Institute on Drug Abuse of the National Institutes of Health now dubs addiction a "chronic and relapsing brain disease," as part of the Institute's attempt to define addiction as simply another long-term medical condition like asthma or high blood pressure. This view, instead of challenging the inevitability of relapse by holding patients accountable for their choices, suggests the need for biological remedies for addiction. It also discounts the therapeutic potential of the coercion that the criminal justice system can exercise.

However, contrary to what this medicalized view would predict, the compulsion to take drugs does not necessarily dominate an addict's minute-to-minute or even day-

to-day existence. The temporal architecture of his or her routine reveals that he is capable of reflection and purposeful behavior for some, perhaps a good deal, of the time. During the course of a heroin addict's day, for example, he may feel calm and his thoughts may be lucid as long as he is confident of access to drugs and he is using them in doses adequate to prevent withdrawal but not large enough to be sedating. Likewise, there are periods in a cocaine addict's week when he is neither engaged in a binge nor wracked with intense craving for the drug. At these moments, he is not a victim controlled by brain disease. He might even choose to change his behavior-- depending on what he thinks is at stake.

This potential for self-control permits society to entertain and enforce expectations of addicts that would never be possible with someone who had, say, a brain tumor. Making such demands is of course no guarantee that they will be met. But confidence in the legitimacy of such demands would encourage a range of policy and therapeutic options, using consequences and coercion, that are incompatible with the idea of an exclusively no-fault brain disease.

Conclusion

Addicts are often extremely ambivalent about giving up drugs, in spite of all the damage that drugs have caused them. Addicts' problems of self-governance demand that a rehabilitative regime for them include limit-setting, consistency, and sometimes physical containment.

Coercion has been applied in the service of rehabilitating addicts for over 70 years. The experience has yielded a powerful clinical lesson: Addicts need not be internally motivated at the outset of treatment in order to benefit from it. Indeed, addicts who are legally pressured into treatment may outperform voluntary patients, because they are likely to stay in treatment longer and are more likely to graduate. Without formal coercive mechanisms, the treatment system would not attract many of the most dysfunctional addicts and surely could not retain them.

But, though official bodies, especially criminal justice organizations, are accustomed to wielding such leverage, they do not do so systematically enough to yield maximum benefit. Some judges will forego referral to treatment altogether if they perceive an offender not to be motivated towards rehabilitation. Other judges express disappointment with the laxity of supervision addicts receive in treatment, citing failure to follow up with the court, verify patient participation, and perform drug testing-- the very surveillance mechanisms that are necessary to retain unmotivated addicts.

Drug courts, in particular, effect a marriage of the so-called medical (voluntary treatment) and moral (sanction-oriented) approaches to addiction — a combination that works better for hard core addicts than either alone.

Addiction is a behavioral condition for which the prescription of choice is the imposition of reliable consequences and rewards, often combined with coercion that keeps the addicted individual from fleeing. To say this is not punitive; it is clinically sound and empirically justified.

Header ;9

Note: on electronic version of this testimony, references are not included. For specific references, please e-mail Dr. Satel <slsatel@aol.com>. The monograph, Drug Treatment: The Case for Coercion (S. Satel, American Enterprise Institute Press, 1999) is a more extensive consideration of this issue and contains annotations as well.

Mr. MICA. Thank you for your testimony.

We will hear next from Martin Iguchi with the RAND Corp. from Santa Monica, CA. You are recognized.

Mr. IGUCHI. Thank you, Mr. Chairman, and thank you for this opportunity to testify.

My name is Martin Iguchi. I am a senior behavioral scientist and co-director of the Drug Policy Research Center at RAND. I am also a psychologist. My specialty over the past decade has been in development and evaluation of drug treatment, drug treatment outcomes, as well as evaluation of different policy initiatives such as drug treatment on demand.

Most recently, we have been also working with L.A. County Probation to set up a DUI Court in Los Angeles, so we have quite a bit of experience in this area.

While the statement is based on research conducted at RAND, the opinions and conclusions are mine and should not be interpreted as representing those of RAND or any other agency sponsoring our research. I ask that my full written statement be entered into the record.

I am pleased to have this opportunity to comment on the use of treatment as an alternative to incarceration as I believe that drug courts and other diversion alternatives are exciting and valuable innovations by the criminal justice system. My colleagues and I have had an opportunity to study this relatively new phenomenon and while I may be counted as a supporter of such courts, I do have a few comments about problems that may arise in implementation.

Over the past several decades, lawmakers in the United States have responded to the drug epidemic with tougher laws and longer sentences in an attempt to deter drug use. The increase in drug cases has resulted in seriously overloaded judicial dockets and a need for reasoned alternatives.

In 1992, the Drug Policy Research Center conducted a drug policy seminar game involving public officials in Florida and Washington, DC, that anticipated such a scenario. The players in that policy game focused, as we are today, on the need to provide drug treatment for those involved in the criminal justice system. This emphasis was consistent with our drug policy modeling work that indicated treatment might well be a more cost effective way to spend additional funds intended to reduce cocaine use than other such options as domestic enforcement, interdiction or source country control.

However, as the drug policy game progressed, players came to realize that they had focused exclusively on the benefits of treatment as an alternative to incarceration with no thought given to the possible negative outcomes associated with the approach in a larger context.

Specifically, they came to realize given the limited availability of treatment slots for those convicted of crimes and those not, they had created a policy that could be characterized as "use a gun, get a treatment slot."

Now I don't mean to overstate the negative here as it is clear that many communities, such as Brooklyn, NY, have been able to implement drug courts without overburdening their drug treatment system.

I do want to raise the issue, however, that we need to be certain there is sufficient treatment capacity to support the increase in drug treatment demand. We do not want those voluntarily seeking treatment to be deprived of the opportunity for treatment because the slot is filled with an individual mandated to it.

To highlight how damaging such a scenario might be, I offer a short anecdote. A colleague of mine runs a drug education outreach and intervention program in south central Los Angeles. This colleague spends a great deal of time educating young men and women about the dangers of drug use and the advantages of abstinence.

Recently, after multiple interactions, he finally convinced two young men to consider treatment for their drug use problem. Unfortunately, my colleague was unable to locate a treatment program with available slots for the two young men. The only publicly funded treatment slots available were set aside for juvenile probationers. This scenario is a tragic one. We need to be certain that we expand treatment in parallel with the development of drug courts so that every person who wants drug treatment can find it.

As a second and related issue, not all who participate in drug use in drug courts are screened to determine if they meet the diagnostic criteria for drug dependence. While this comment does not apply to research rich programs such as the Brooklyn Drug-Treatment Alternative to Prison Programs, many programs are not as discriminating. This means that many individuals are sent to drug treatment who do not require it, putting additional pressure on an often overburdened system of care.

My third comment has to do with the question, "who should run drug courts, prosecutors or judges?" A number of drug courts are operated by the prosecutor's office rather than by judges. While I do not question the integrity of prosecuting attorneys, some public defenders and defense attorneys have voiced concern that prosecutors might be tempted to offer access to drug courts only to those who are "cooperative."

While the functional and daily operational characteristic of prosecutor courts appear identical to drug courts run by judges, I want to provide a word of caution about the importance of avoiding perceptions of pressure on defendants. For that reason, it seems reasonable that judges and not prosecutors should be in charge of drug courts.

Finally, I want to say that I have been most impressed by the dedicated and enthusiastic efforts put forth by those involved in both the judicial and treatment communities to make drug courts around the country work. While drug courts are clearly responsible for a decrease in the pressures of overcrowded court dockets, the daily workloads of everyone involved in drug courts has actually increased.

So what leads these dedicated professionals to give so much more of themselves for drug court? The answer from all involved appears to be that the idea of restorative justice or therapeutic jurisprudence is a hopeful one in a context that breeds cynicism.

I attended a drug court graduation ceremony in Rancho Cucamonga this month and had a conversation with the court magistrate. He stated he looks forward to ending his week with drug

court every Friday evening. He elaborated that during his normal work day, he is faced with doing unpleasant things to people who have engaged in bad behavior. But on Friday evening, he sees hope and the possibility of rehabilitation. He concluded, "It is definitely worth the extra work."

Thank you for your attention to this important matter.

[The prepared statement of Mr. Iguchi follows:]

T E S T I M O N Y

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Testimony on Treatment Alternatives to Incarceration

Martin Y. Iguchi

CT-169

April 4, 2000

Drug Policy Research Center

The RAND testimony series contains statements of RAND staff members exactly as delivered.

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Testimony Before The House Government Reform And Oversight Committee

Subcommittee On Criminal Justice, Drug Policy, And Human Resources

Tuesday, April 4, 2000

Martin Y. Iguchi

Thank you for the opportunity to testify. My name is Martin Iguchi. I am a Senior Behavioral Scientist and Co-Director of the Drug Policy Research Center at RAND. While this statement is based on research conducted at RAND, the opinions and conclusions are mine and should not be interpreted as representing those of RAND or any of the agencies or others sponsoring its research. I ask that my full written statement be entered into the record.

I am pleased to have this opportunity to comment on the use of treatment as an alternative to incarceration as I believe the rapid spread of drug courts and other diversion alternatives now available in this country to be exciting and valuable innovations by the criminal justice system. My colleagues and I have had an opportunity to study this relatively new phenomenon, and while I may be counted as a supporter of such courts, I do have a few comments about problems that may arise in implementation.

Over the past several decades, lawmakers in the United States have responded to the drug epidemic with tougher laws and longer sentences in an attempt to deter drug use. The resulting increase in drug cases has resulted in seriously overloaded judicial dockets and a need for reasoned alternatives. In 1992, the Drug Policy Research Center (DPRC) conducted a drug policy seminar game that anticipated

just such a scenario. Players in that policy game focused, as we are today, on the need to provide drug treatment for those involved in the criminal justice system. This emphasis was consistent with our drug policy modeling work that indicated treatment was the most cost-effective means for controlling cocaine use when compared with other cocaine control options such as domestic enforcement, interdiction, or source country control [1]. However, as the drug policy game progressed, players came to realize that they had focused exclusively on the benefits of treatment, with no thought given to possible negative outcomes associated with the approach in a larger context. Specifically, they came to realize that in the larger context of limited treatment availability, they had created a policy that could be characterized as, "Use a gun, get a treatment slot [2]."

Now I don't mean to overstate the negative here as it is clear that many communities (such as Brooklyn, New York) have been able to implement drug courts without overburdening their drug treatment system. I do want to raise the issue, however, that we need to be certain that there is sufficient treatment capacity to support the increase in drug treatment demand. We do not want those voluntarily seeking treatment to be deprived of the opportunity for treatment because the slot is filled with an individual mandated to treatment.

To highlight how damaging such a scenario might be, I offer a short anecdote. A colleague of mine runs a drug education, outreach, and intervention program in South Central Los Angeles. This colleague spends a great deal of time educating young men and women about the dangers of drug use and of the advantages of abstinence. Recently, after multiple interactions, he finally convinced two young men to consider treatment for their drug use problem. Unfortunately, my colleague was unable to locate a treatment program with an available slot for the two young

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As a second and related issue, not everyone who participates in drug courts are screened to determine if they meet the diagnostic criteria for drug dependence. While this comment does not apply to resource rich programs such as the Brooklyn DTAP program, many courts are not as discriminating. This means that many individuals are sent to treatment programs that do not require drug treatment, putting additional pressure on an often overburdened system of care.

My third comment has to do with the question, "who should run drug courts – prosecutors or judges?" A number of drug courts, such as the DTAP program in Brooklyn, are operated by the prosecutors' office, rather than by judges. While I do not question the integrity of prosecuting attorneys, there are public defenders and defense attorneys who have voiced concern that prosecutors might be tempted to offer access to drug court only to those that are "cooperative." While the functional and daily operational characteristics of prosecutor courts appear identical to drug courts run by judges, I want to provide a word of caution about the importance of avoiding perceptions of pressure. For that reason, it seems reasonable that judges, not prosecutors, should be in charge of drug courts.

Finally, I want to comment that I have been most impressed by the dedicated and enthusiastic efforts put forward by those involved in both the judicial and treatment communities to make drug courts work around the country. While drug courts are clearly responsible for decreasing the pressures of overcrowded court

dockets, the daily work loads of everyone involved in drug court is actually increased. So what leads these dedicated professionals to give so much more of themselves for drug court? The answer, from all involved appears to be that the idea of restorative justice or therapeutic jurisprudence is a hopeful one in context that breeds cynicism. I attended a drug court graduation ceremony in Rancho Cucamonga this month and I had a conversation with the court magistrate. He stated that he looks forward to ending his week with drug court every Friday evening. He elaborated that during his normal work-day he is faced with doing nothing but crummy things to people who have engaged in crummy behavior. But on Friday evening, he sees hope and the possibility of rehabilitation. He concluded, "It's definitely worth the extra work."

Thank you for your attention to this important matter.

ENDNOTES

[1] See C. Peter Rydell and Susan S. Everingham (1994) "Controlling Cocaine: Supply versus Demand Programs, RAND, MR-331-ONDCP/A/DPRC

[2] See "Developing games of local drug policy." (1992) James P. Kahan, John Setear, Margaret M. Bitzinger, Sinclair B. Coleman, Joel Feinlab. RAND, N-3395-DPRC.

Mr. MICA. Thank you for your testimony, each and every one of you.

Unfortunately, I have to disagree with some of the products of your corporation, Mr. Iguchi. I think in particular, the RAND study has probably done more damage to this whole effort than anything I have seen in 20 years of dealing with the drug problem.

Last week, during the debate that we had on the floor, we heard repeatedly this garbage that was spewed by the study some years ago and used by many of those who come forward with a solution that just treatment on demand is the answer. It has created, I think, a disaster for this country. That happens to be my personal opinion.

I think this administration took the RAND study and used it as an excuse to shut down the source country programs and with great difficulty we have been trying to get those programs put back in place. The most recent is the ongoing effort starting last week to get something targeted to Colombia where we know shutting down the interdiction and shutting down the source country programs has created not only a flood of narcotics unlike we even saw in the 1980's, but a more deadly brand, so that 15,973 Americans in 1998, the latest figure that I have received as chairman of the subcommittee, didn't even get a chance for voluntary treatment because they are dead.

I think that some of the trash that was put out that has been used for substantiation of just provide treatment, we have nearly doubled the amount of treatment money since 1992 than we have the amount of money in interdiction in source country programs. With $20-$40 million in Peru and Bolivia over the last few years, we have dramatically cut the supply coming in and stopped the programs in Colombia which are now the source of 80–90 percent of 80 percent pure heroin and cocaine coming into this country.

Your study, in my opinion, has done more damage and substantiated a false and ineffective approach because you will never end up treating all the people that you are now opening up to addiction with the incredible supply that is coming into this country. If you could stop the supply, we could put you and your study colleagues out of business because we wouldn't have to even deal with this topic before us.

Did you want to respond?

Mr. IGUCHI. I am not fully prepared to respond to that particular criticism. I, frankly, didn't come prepared to defend our "Controlling Cocaine" report. We do, however, stand by the integrity of our "Controlling Cocaine" report. It was reviewed by the National Academy of Sciences and held up as a very reasonable frame for viewing policymaking decisions. People may quibble with some of the numbers that were input into that model, but in evaluation after evaluation of it, we have come away convinced that it is a very strong model and it is a suitable basis for making policy decisions.

Mr. MICA. It is a strong model for what? It has been used as an example for the treatment on demand. I don't have a problem with treatment on demand, but if you have a torrent of narcotics coming in and you are creating an addiction population.

We went to Baltimore a week ago and the predictions are somewhere in the neighborhood of 80,000 drug addicts where they have had a liberalization, where they have focused primarily on treatment. They can't keep up with the treatment. Then 50 percent of the folks don't even show up for treatment in the program. I am very concerned that some of these think tanks like yours put out things that are used as justification for only treatment and then we shelve—and this administration shelved the interdiction, cut by 50 percent, and took the military out.

We have reports of now cutting out the surveillance to Peru where we have had such great success, 66 percent reduction and not providing that assistance so they could go after these traffickers so that the stuff isn't in the country.

In order to qualify for treatment, the big myth in this whole thing is when you get to the point of treatment, that means you are addict. If you are an addict, that means the testimony we have seen, the people we have interviewed in prison have committed crimes of violence to the tune of habits they support for $100 to $500 a day, many of them committing felonies.

By the time they get to your treatment on demand, it has made a joke of the whole system and we have created someone we can't deal with. All the programs they are talking about here today are only talking about tiny fractions—drug courts, tiny fractions—even DTAP, a tiny fraction.

Yes, we want to help them, but in DTAP most of the people we talked to had spent half their lives in prison or in the judicial cycle. So the treatment on demand is great, but half of those folks don't even want to get in the program or don't show up for the program. The only reason they show up for DTAP is they are in prison or they have no choice that they are going to go back to prison.

Again, I think the RAND Corp.—it is nice to have you here today but I think some of your past studies and conclusions have done tremendous damage—maybe you were well intended—but by people who were advocates of this one avenue of approach.

Mr. IGUCHI. Mr. Chairman, we can only deal with the numbers and data that we have. The studies that have been conducted supply the data that go into those kinds of models, and we stand by them.

The problem with focusing on supply reduction is that we don't have demonstrated effective supply reduction methodologies.

Mr. MICA. That is crap. That is baloney. I can get the charts out here and we can look at what we did with the Andean strategy, with the South Americans, and with the Vice President's Task Force for going after the stuff. If you want a concentrated program for a few bucks in some of these countries where the peasants are getting a couple of pesos for that crap, you can stop it. There is no question about it. We did it in Peru.

Mr. IGUCHI. We did it temporarily.

Mr. MICA. We did it with President Fujimora. Mr. Hastert, who chaired this subcommittee before me, went down and we talked to those folks. Ten years ago, you couldn't even walk on the streets of Lima because there were bombs going off. The Shining Path was ruling the roost and they were also profiting from the drug trade.

We brought that under control, cut it by 66 percent. We can do the same thing anywhere we want if we have the will.

Even now the President's own Ambassador to that country has sent letters to this administration that again, they are changing their policy of not providing the intelligence and surveillance information that allows them to shoot down the drug traffickers. It sure as hell will stop anybody on treatment if you shoot down a plane that is carrying cocaine out of that country to the United States. Then you don't have to worry about treating them because they don't have the drugs in the first place to be addicted to get on the treatment program that a lot of them won't even show up or are interested in treatment in the first place.

Mr. IGUCHI. I am well aware of——

Mr. MICA. Mrs. Mink, you are recognized.

Mrs. MINK. Mr. Chairman, that was an astonishing outburst, unforgivable.

Mr. MICA. Sorry. I apologize.

Mr. MINK. The witness that I invited to this committee, Martin Iguchi, I am sure had nothing to do with the 8-year old report of the RAND Corp.

Mr. MICA. And I didn't accuse him personally.

Mrs. MINK. You kept saying, "you, you" and I found that——

Mr. MICA. The RAND Corp., for the record.

Mrs. MINK. He is not the RAND Corp., although maybe at times he wishes he were. He simply is an investigator, senior behavioral scientist, co-director of the Drug Policy Research Center at RAND. He doesn't run the entire gamut of the RAND Corp. investigative research activities, I am sure. Do you?

Mr. IGUCHI. No, I do not.

Mrs. MINK. I apologize, Mr. Iguchi, for their asking you to answer for the entire RAND Corp.'s research outcomes.

We debated this last week and that is why it is still very much in the environment here because we were debating it last week but the RAND Corp., Mr. Chairman, never stated specifically that activities to curtail supply were not appropriate for this government. I certainly support, as you well know, all efforts that we can engage in to limit the supply but our efforts should not be limited to only the questions of supply but this country has not paid enough attention, as I said on the floor last week, to the whole area of treatment.

Efforts have to be made to encourage State and local governments to do more as they are doing in the drug court area and local prosecutors need to be encouraged to do more in their specific areas. So the purpose of this hearing, the purpose of inviting Mr. Iguchi to testify, was to get his insights on the engagement of the criminal justice system into drug treatment and whether it is efficient and whether it is appropriate. It is a question of both.

We know that those that exist are efficient. I have visited some, read some of the statements and documents and reports on it. The question that Mr. Iguchi raises is the most important question that we should be debating. That is the preferential selection of individuals to go into these DTAP or drug court programs, require that these two areas have special abilities to get drug treatment programs for their clients.

They would be ineffective if while talking to a potential enrollee, there was not a space somewhere to put that individual into a drug treatment program. The whole thing must be interconnected. Whether you are the judge or the prosecutor is irrelevant; you have to have a special privileged line somewhere to get into the program. Otherwise you are just talking in the wind, if only 6 months from now a space will open for you.

That is the condition of the public at large today. We can't take everybody who voluntarily says I have a drug problem and I really need help. Instead we say to that individual, you have to wait 6 months; there is no space. But if you commit a crime, you can go to drug court, and they will take care of you. That is a terrible alternative. I think Mr. Iguchi raises that point and that is a very troubling point which goes back ultimately to what the chairman is upset about, and that is our concern about the lack of availability of drug treatment programs in this country.

Less than 50 percent of those who seek it are able to get it. Our anxieties are really raised because we want to see more of these treatment programs, not that it is the end all, cure all, but that it is a necessity. If we are going to be honest about trying to help people who have a drug problem, we have to find more funds to create these treatment programs.

You testified, Mr. Belenko, that there was a 66 percent retention rate in the treatment programs. That was a question that Representative Ose asked. That is a confusing statement. Exactly what is meant by that statement, there is a 66 percent retention rate in the substance treatment program by those that are in either drug court or DTAP?

Mr. BELENKO. That figure was referring to the DTAP program. What that means is that of those who start the program, 66 percent of them are still in treatment 1 year later. So it is 1 year.

Mrs. MINK. And already detached from DTAP, no longer under the supervision?

Mr. BELENKO. In DTAP. DTAP requires 15 to 24 months.

Mrs. MINK. Even with that coercion as an alternative to going to prison, you only have a 66 percent retention in a treatment program?

Mr. BELENKO. I think you have to compare it to retention in residential treatment generally which is quite low where only probably 10 to 30 percent of those who enter residential treatment are still there after 1 year. Generally, residential treatment requires long term.

Mrs. MINK. What happens to that 34 percent then that don't stay in the program? They are then pushed into the regular criminal justice system and ultimately go to jail?

Mr. BELENKO. They are prosecuted and under the DTAP model, as the district attorney has designed it, these are offenders who are subject to mandatory prison sentences. In fact, 96 percent of them are returned to court, are prosecuted and sentenced to the prison terms they would have gotten had they not gone to DTAP.

Mrs. MINK. The clients that are identified for either drug court or DTAP, how are they able to assure their clients the ability to enter a treatment program?

Mr. BELENKO. In both models, there are treatment slots dedicated by prior agreement.

Mrs. MINK. By prior agreement, by State law or whatever?

Mr. BELENKO. Yes, through various funding mechanisms.

Mrs. MINK. So that sets the limits on the number that DTAP can take or the number the drug court can take, the availability of drug treatment slots.

Mr. BELENKO. I want to also point out that generally drug courts are set up with an existing treatment infrastructure in place so that they know when participants come into a drug court, there will be a treatment slot.

Mrs. MINK. They run their own, maintain their own?

Mr. BELENKO. Some drug courts operate their own, others use existing community-based providers, others contract with a single provider in the community.

Mrs. MINK. But still, the limitation is availability of drug treatment slots?

Mr. BELENKO. That is always the limitation, yes.

Mrs. MINK. If there was not such a limitation and drug treatment spaces were readily available through out the country, what would be that effect on the number of people that would be in the program? Would it double the program, triple the program, quadruple it?

Mr. BELENKO. There are still limitations because at some point drug court staff would be overwhelmed with cases. As under traditional probation where probation officers may have 150 to 200 probationers to supervise, you don't want a drug course where a case manager or a judge has to supervise too many cases because I think some individual attention is required. So there may be limits in a single courtroom of how many cases you want, but certainly there is room for expansion.

Mrs. MINK. In the usual congressional budget-type analysis, the question would be put what is the average cost per client in the drug court system, maintained in the drug court system as against the DTAP system, as against going to prison?

Mr. BELENKO. Judge Tauber mentioned the figure, I think, of $2,000 per year.

Mrs. MINK. $2,000 in DTAP?

Mr. BELENKO. For drug court. Drug courts generally use outpatient treatment models which is much cheaper than residential. DTAP uses a residential treatment model which is more expensive, my guess would be $10,000-$15,000 per year.

Mrs. MINK. DTAP clients are typically detained in residential centers?

Mr. BELENKO. They are required to be in residential treatment under a therapeutic community model which is very intensive and long-term treatment. The average cost of a prison nationwide, is probably about $22,000 a year or so. In New York, it is closer to $30,000, I believe. Prison is clearly the most expensive; residential is much cheaper. Outpatient treatment, which most drug courts use, is even cheaper than that. Relatively inexpensive, not cheap.

Mrs. MINK. Thank you, Mr. Chairman.

Mr. MICA. Thank the gentlelady. I am sorry for berating your witness today. I just saw RAND Corp., and Mr. Iguchi has been before us and I have been very polite to him.

Mrs. MINK. You should apologize to him for ranting and raving.

Mr. MICA. After hearing a day and a half of debate.

Mrs. MINK. I thought it was a brilliant debate, especially my part.

Mr. MICA. You were, in fact, brilliant, but using the RAND Corp. study of past in such a distorted fashion.

Mrs. MINK. Don't start again or I will take another 5 minutes.

Mr. MICA. I don't know if Mr. Iguchi was involved in that study, I am sure he wasn't.

Mr. IGUCHI. I joined the RAND Corp. 2 years ago.

Mrs. MINK. You didn't extend him the courtesy of asking if he was there.

Mr. MICA. Just representing the corporation that did the study that I felt did a lot of damage.

Mrs. MINK. He specifically said in his opening, I do not represent the corporation today.

Mr. MICA. He had to bear the brunt of it and if you want to hear more, tune in tonight for 1 hour in special orders when I will finish my comments about the misuse of the study. I am sure the RAND Corp. does very good in compiling statistics and data in a fairly level, non-biased fashion but again, the misuse of that concerns me.

My concern is that the programs we have heard of today are great. They do serve a very small portion of the population and in order to qualify for those programs, those individuals have had to reach addiction, the need for treatment, had to have committed a crime, in many cases serious crimes and felonies, and they have also had to face the possibility of prison and my concern is that it is much more cost effective if we want to do a cost benefit analysis, if those individuals are never subjected in the first place to even using illegal narcotics and then also a balanced approach. I have never advocated not doing treatment or any of these programs. They are necessary but when you take out key elements, you put yourself at risk, again subjecting more people to becoming victims of illegal narcotics addiction, use of treatment which follows and prison, all of which have even marginal success rates, even these that we have heard from today.

I do want to thank all of our witnesses for providing testimony before us today. It does help us, particularly with the model of the DTAP Program. We hopefully can support that nationally. We are already supporting the drug courts nationally and I hope that support will continue and we can have successful programs in both areas.

There being no further business to come before the subcommittee at this time, this hearing is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

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